MEDICARE CATASTROPHIC PROTECTION ACT OF 1987

JULY 1, 1987.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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Mr. DINGELL, from the Committee on Energy and Commerce, submitted the following

REPORT

together with

DISSENTING VIEWS

[To accompany H.R. 2470 which on May 19, 1987, was referred jointly to the Committee on Ways and Means and the Committee on Energy and Commerce]

[Including cost estimate of the Congressional Budget Office]

The Committee on Energy and Commerce, to whom was referred the bill (H.R. 2470) to amend title XVIII of the Social Security Act to provide protection against catastrophic medical expenses under the Medicare Program, and for other purposes, having considered the same, reports favorably thereon with amendments and recommends that the bill as amended do pass.

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The Amendment

The amendments are as follows:

Page 2, the table of contents is amended by striking the items relating to title II and inserting the following:

TITLE II—PROVISIONS RELATING TO PART B OF THE MEDICARE PROGRAM AND TO THE MEDICAID PROGRAM

Sec. 201. Limitation on medicare out-of-pocket expenses under part B.
Sec. 202. Coverage of catastrophic expenses for prescription drugs and insulin.
Sec. 203. In-home care for certain chronically dependent individuals.
Sec. 204. Extending home health services.
Sec. 205. Increase in maximum payment allowed for outpatient mental health services.
Sec. 206. Coverage of influenza vaccine and its administration.
Sec. 207. Mailing of notice of medicare benefits and participating physician directories.
Sec. 208. Requiring medicaid buy-in of premiums and cost-sharing for poor medicare beneficiaries.
Sec. 209. Adjustment in medicare part b premium.
Sec. 210. Changes in certification of medicare supplemental health insurance policies.
Sec. 211. Extension of social HMO demonstration project.
Sec. 212. Study on comprehensive medical coverage under the medicare program.
Sec. 213. Research on long-term care services for medicare beneficiaries.
Sec. 214. Protection of income and resources of couple for maintenance of community spouse.
Sec. 215. Study of adult day care services.

TITLE III—UNITED STATES BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE

Sec. 301. Establishment.
Sec. 302. Duties.
Sec. 303. Membership.
Sec. 304. Staff and consultants.
Sec. 305. Powers.

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Sec. 306. Report.
Sec. 307. Termination.
Sec. 308. Authorization of appropriations.

Page 27, strike out line 10 and all that follows through page 48, line 6, and insert the following:

TITLE II—PROVISIONS RELATING TO PART B OF THE MEDICARE PROGRAM AND TO THE MEDICAID PROGRAM

SEC. 201. LIMITATION ON MEDICARE OUT-OF-POCKET EXPENSES UNDER PART B.

(a) IN GENERAL.—Section 1833 (42 U.S.C. 1395l) is amended—

(1) by inserting after subsection (e) the following new subsection:

"(f)(1) Notwithstanding subsections (a) and (b), if an individual has incurred out-of-pocket part B expenses (as defined in paragraph (2)) in a calendar year (beginning with 1989) in an amount equal to the part B catastrophic limit (established under paragraph (3)) for the year, payment under this part with respect to any additional incurred expenses in the calendar year shall be made as if—

"(A) the deduction described in the second sentence of subsection (b) (relating to blood) no longer applied, and

"(B) '100 percent' and '0 percent' were substituted for '80 percent' and '20 percent', respectively, each place either appears in subsection (a), in section 1833(i)(2), in section 1835(b)(2), and in subsections (b)(2) and (b)(3) of section 1881.

"(2) In this subsection, the term 'out-of-pocket part B expenses' means—

"(A) the deductions established under subsection (b), and

"(B) the difference between the payment amount provided under this part and the payment amount that would be provided if '100 percent' and '0 percent' were substituted for '80 percent' and '20 percent', respectively, each place either appears in subsection (a), in section 1833(i)(2), in section 1835(b)(2), and in subsections (b)(2) and (b)(3) of section 1881.

Such term also includes reasonable expenses (as defined by the Secretary) incurred for an annual colorectal examination for cancer and reasonable expenses (as defined by the Secretary) incurred for a mammogram, once every third year, for detection of breast cancer.

"(3)(A) The part B catastrophic limit for 1989 is $1,043. The part B catastrophic limit for any succeeding year shall be an amount equal to the part B catastrophic limit for the preceding year increased by the applicable increase percentage determined under section 215(i) in the previous year. Any amount determined under the preceding sentence which is not a multiple of $1 shall be rounded to the nearest multiple of $1 (or, if it is a multiple of 50 cents but not a multiple of $1, to the next higher multiple of $1).

"(B) Not later than November 15 of each year (beginning with 1988), the Secretary shall promulgate the part B catastrophic limit under this paragraph for the succeeding year.

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"(4) In applying paragraph (1) in the case of an organization receiving payment under clause (A) of subsection (a)(1) or under a reasonable cost reimbursement contract under section 1876—

"(A) the Secretary shall provide for an appropriate adjustment in the payment amounts otherwise made to reflect, in the aggregate, the aggregate increase in payments that would otherwise be made with respect to enrollees in the organization if payments were made other than under such clause or such a contract or with respect to individuals furnished services through the facility if payments were to be made on an individual-by-individual basis, and

"(B) the organization or facility shall provide assurances satisfactory to the Secretary that the organization or facility will not undertake to charge an individual during a year for services for which payment may be made under this part after the individual has incurred (whether through the organization, facility or otherwise) out-of-pocket part B expenses in the year in an amount equal to the part B catastrophic limit established under paragraph (3) for the year."; and

(2) in subsections (c) and (g), by striking "(a) and (b)" each place it appears and inserting "(a), (b), and (f)".

(b) LIMITATION ON CHARGES WHEN CATASTROPHIC LIMIT REACHED.—Section 1866(a)(2)(A) (42 U.S.C. 1395cc(a)(2)(A)) is amended by adding at the end the following new sentence: "A provider of services may not impose a charge under the first sentence of this subparagraph for services for which payment is made to the provider pursuant to section 1833(f) (relating to catastrophic benefits).".

(c) ENCOURAGING RESTRAINT ON BALANCE BILLING FOR BENEFICIARIES REACHING CATASTROPHIC LIMIT.—Section 1842(b)(3) (42 U.S.C. 1395u(b)(3)) is amended—

(1) by striking "and" at the end of subparagraph (G),

(2) by inserting "and" at the end of subparagraph (H), and

(3) by inserting after subparagraph (H) the following new subparagraph:

"(I) if it makes determinations or payments with respect to items and services furnished by a physician for which payment is made pursuant to section 1833(f) but not on an assignment-related basis, provide to the physician a notice that—

"(i) states that the individual provided the service has reached the part B catastrophic limit on out-of-pocket expenses for the year, and

"(ii) encourages the physician not to charge the individual amounts in excess of the reasonable charge recognized under this section and to accept payment on an assignment-related basis for physicians' services furnished the individual during the remainder of the year;".

SEC. 202. COVERAGE OF CATASTROPHIC EXPENSES FOR PRESCRIPTION DRUGS AND INSULIN.

(a) IN GENERAL.—Section 1861 (42 U.S.C. 1395x) is amended—

(1) by amending subaragraph (J) of subsection (s)(2) to read as follows:

"(J) covered outpatient drugs (as defined in subsection (t)(2)); and"; and

(2) in subsection (t)—

(A) by striking "subsection (m)(5)" and inserting "subsections (m)(5) and (s)(2)(J) and paragraph (2)",

(B) by inserting "(1)" after "(t)", and

(C) by adding at the end the following new paragraph:

"(2) The term 'covered outpatient drug' means—

"(A) a drug which—

"(i) is approved for safety and effectiveness as a prescription drug under section 505 or 507 of the Federal Food, Drug, and Cosmetic Act, or

"(ii) in the case of a drug which is biological product, is licensed under section 351 of the Public Health Service Act, and

"(B) insulin certified under section 506 of the Federal Food, Drug, and Cosmetic Act;

but does not include any drug or insulin provided to an inpatient as part of inpatient hospital services (described in subsection (b)(2)), as part of extended care services (described in subsection (h)(5)), or as an incident to physicians' services under subparagraph (A) or (B) of subsection (s)(2).".

(b) DEDUCTIBLE AND PAYMENT AMOUNTS.—

(1) IN GENERAL.—Section 1833 (42 U.S.C. 1395l(b)) is amended—

(A) in subsection (a)(1)—

(i) by striking "and" before "(H)", and

(ii) by adding at the end the following: "and (I) with respect to expenses incurred for covered outpatient drugs, the amounts paid shall be the amounts determined under subsection (m)(2),";

(B) in subsection (b)—

(i) in clause (1), by inserting "or for covered outpatient drugs" after "1861(s)(10)(A)", and

(ii) in clause (2), by inserting "or with respect to covered outpatient drugs" after "home health services"; and

(C) by adding at the end the following new subsection:

"(m)(1)(A) Before applying paragraph (2) with respect to expenses incurred by an individual for covered outpatient drugs dispensed in a calendar year, the individual must establish that the individual has incurred expenses for such drugs dispensed in the year (during a period in which the individual is a entitled to benefits under this part) of the amount specified in subparagraph (C) for that year.

"(B) If an individual applies to the Secretary to establish that the individual has met the requirement of subparagraph (A), the Secretary shall promptly notify the individual (and, if the application was submitted by or through a participating pharmacy, the pharmacy) as to whether or not the individual has met such requirement.

"(C) The amount specified in this subparagraph for 1989 is $500. For each subsequent year, subject to subparagraph (D), the amount specified in this subparagraph is the amount specified in this subparagraph for the previous year increased by percentage change in

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the medical care component of the consumer price index for all urban consumers (U.S. city average, as published by the Bureau of Labor Statistics) during the 12-month period ending with August in that previous year. Any amount determined under the preceding sentence which is not a multiple of $1 shall be rounded to the next highest multiple of $1. In September of each year (beginning with 1989) the Secretary shall publish the deductible established under this subparagraph for the following year.

"(D) If the monthly actuarial rate determined under section 1839(g)(1) for a year (after 1990) exceeds 120 percent of the monthly premium increase provided under section 1839(g)(2) for months in the preceding year, the Secretary shall increase the amount otherwise specified under subparagraph (C) for that year (and only for that year) by such an amount as will assure that—

"(i) the aggregate amount of the monthly premium increase provided under section 1839(g) for the year for all enrollees,

is equal to—

"(ii) the total of the benefits and administrative costs which the Secretary estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for covered outpatient drugs dispensed and related administrative costs incurred in such year for all such enrollees.

"(2) Subject to the deductible established under paragraph (1)(A), the amount payable under this part with respect to a covered outpatient drug is equal to the actual charge for the drug, or, if lower, the applicable payment limit described in paragraph (3).

"(3)(A) In the case of a covered outpatient drug that either is not a multiple source drug (as defined in paragraph (6)(A)) or is a multiple source drug and has a restrictive prescription (as defined in paragraph (6)(B)), the payment limit for the drug under this paragraph is the sum of—

"(i) the product of (I) the number of tablets (or other dosage units) dispensed and (II) the average per tablet or unit wholesale price for the drug (as determined under paragraph (4)), and

"(ii) an administrative allowance of $4.50.

"(B) In the case of a covered outpatient drug that is a multiple source drug but does not have a restrictive prescription, the payment limit for the drug under this paragraph is the sum of—

"(i) the product of (I) the number of tablets (or other dosage units) dispensed and (II) the amount specified under subparagraph (C), and

"(ii) an administrative allowance of $4.50.

"(C) The amount specified under this subparagraph with respect to a multiple source drug dispensed in a year is 50 percent of the highest of the average per tablet or unit wholesale price for any drug product described in paragraph (5)(A) with respect to that drug, as in effect as of January 1, 1987, increased, for each year after 1987 and up to the year involved, by the percentage increase in the consumer price index for all urban consumers (all items, U.S. city average, as published by the Bureau of Labor Statistics) for the 12-month period ending in August of the previous year.

"(D) The Secretary, before each payment calculation period (as defined in paragraph (5)(C)), shall provide for the distribution to

participating pharmacies (as defined in section 1842(i)) and to groups representing or assisting individuals entitled to benefits under this part, of information on the payment limits established under this paragraph.

"(4)(A) For purposes of this subsection, the Secretary shall determine, with respect to dispensing of each covered outpatient drug in each payment calculation period, the average per tablet or unit wholesale price for the drug. Such average shall be based on the average wholesale price (or when available, the manufacturer's direct price) for purchases in reasonable quantities. Such determination shall be made for each payment calculation period based on wholesale or direct prices for the first day of the third month before the beginning of the period. The Secretary shall make such determination, and calculate the payment limits under paragraph (3), on a national basis; except that the Secretary may make such determination, and calculate such payment limits, on a regional basis to take account of limitations on the availability of drug products and variations among regions in the average wholesale or direct price for a drug product.

"(B) In order to prevent abusive practices in the prescribing or dispensing of covered outpatient drugs, the Secretary may provide that payment for covered outpatient drugs may not be made in they are prescribed or dispensed with excessive frequency or in excessive quantities.

"(5) In this subsection:

"(A) The term 'multiple source drug' means, with respect to a payment calculation period, a covered outpatient drug for which there are 2 or more drug products which—

"(i) are considered to be therapeutically equivalent (under the Food and Drug Administration's most recent publication of 'Approved Drug Products with Therapeutic Equivalence Evaluations', available on the first day of the third month before the beginning of the period), and

"(ii) are sold or marketed during the period.

For purposes of clause (ii), a drug is considered to be sold or marketed during a period if it is listed in the publications referred to in clause (i) for the third month before the beginning of the period, unless the Secretary determines that such sale or marketing is not actually taking place.

"(B) A drug has a 'restrictive prescription' only if the the prescription for the drug indicates, in the handwriting of the physician or other person prescribing the drug and with an appropriate phrase (such as 'brand medically necessary') recognized by the Secretary, that the particular drug must be dispensed.

"(C) The term 'payment calculation period' means the 6-month period beginning with January of each year (after 1988) and the 6-month period beginning with July of each year (after 1988).".

(2) REPORT ON PAYMENT LIMITS.—The Secretary of Health and Human Services shall review the payment limits described in section 1833(m)(3) of the Social Security Act on covered outpatient drugs and shall report to Congress, by not later than April 1, 1989, on the appropriateness of such limits. The Secre-

tary shall include in such report such recommendations for changes in such limits as may be appropriate.

(c) PARTICIPATING PHARMACIES.—Section 1842 (42 U.S.C. 1395t) is amended—

(1) in subclauses (III) and (IV) of subsection (c)(2)(B)(ii), by inserting "or by participating pharmacies" after "participating physicians" each place it appears;

(2) in subsection (h)(1), by inserting before the period at the end of the second sentence the following: "and, with respect to a supplier of covered outpatient drugs, is a participating pharmacy (as defined in subsection (i)(1))"; and

(3) by adding after subsection (h) the following new subsection:

"(i)(1) For purposes of this section, the term 'participating pharmacy' means an entity which is authorized under a State law to dispense covered outpatient drugs and which has entered into an agreement with the Secretary, providing at least the following:

"(A) The entity agrees—

"(i) not to refuse to dispense covered outpatient drugs items stocked by the entity to any individual entitled to benefits under this part (in this section referred to as 'medicare beneficiaries'), and

"(ii) not to charge medicare beneficiaries more for such drugs than the amount it charges to the general public.

"(B) The entity agrees to keep patient records (including records on expenses incurred by medicare beneficiaries) for all covered outpatient drugs dispensed to all such beneficiaries.

"(C) The entity agrees—

"(i) to assist medicare beneficiaries in determining whether or not their expenses (for covered outpatient drugs dispensed in a year) have exceeded the deductible under section 1833(m)(1)(A), including providing the documentation necessary to establish this, and

"(ii) on behalf and on the request of such a beneficiary, to submit to the carrier such documentation as the Secretary requires.

"(D) The entity agrees, upon request of a medicare beneficiary, to provide a copy of the records maintained under subparagraph (B) to another participating pharmacy or to a carrier under this section.

"(E) The entity agrees—

"(i) to offer to counsel, or to offer to provide information to, each medicare beneficiary on the appropriate use of a drug to be dispensed and whether there are potential interactions between the drug and other drugs dispensed to the beneficiary; and

"(ii) to advise the beneficiary on the availability (consistent with State laws respecting substitution of drugs) of therapeutically equivalent covered outpatient drugs.

"(2) The Secretary shall provide to each participating pharmacy—

"(A) a distinctive emblem (suitable for display to the public) indicating that the pharmacy is a participating pharmacy, and

"(B) before the beginning of each payment calculation period, information on the payment limits established under paragraphs (3) and (4) of section 1833(m).

"(3) The Secretary shall provide for periodic audits of participating pharmacies to assure that they do not impose charges in excess of the amounts permitted under paragraph (1)(A)(ii).

"(4) Notwithstanding subsection (b)(3)(B), payment for covered outpatient drugs may be made on the basis of an assignment described in clause (ii) of that subsection only to a participating pharmacy.".

(d) ADDITIONAL PREMIUM FOR PRESCRIPTION DRUG BENEFIT.—Section 1839 (42 U.S.C. 1395r) is amended—

(1) in the second sentence of subsection (a)(1), by inserting "(other than costs relating to covered outpatient drugs)" before the period;

(2) in subsection (a)(2), by striking "and (e)" and inserting ", (e), and (g)";

(3) in subsection (a)(3), by striking "subsection (e)" and inserting "subsections (e) and (g)";

(4) in the second sentence of subsection (a)(4), by inserting "(other than costs relating to covered outpatient drugs)" before the period; and

(5) by adding at the end the following new subsection:

"(g)(1)(A) The Secretary shall, during September of 1987 and of each year thereafter, determine a monthly actuarial rate for covered outpatient drugs which shall be applicable for the succeeding calendar year.

"(B) Subject to subparagraph (C), such actuarial rate shall be the amount the Secretary estimates to be necessary so that the aggregate amount for such calendar year with respect to enrollees will equal 100 percent of the total of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for covered outpatient drugs dispensed and related administrative costs incurred in such calendar year with respect to such enrollees.

"(C) In establishing the monthly actuarial rate under this paragraph for each year (after 1990), the Secretary shall take into account any net surplus or deficit of the aggregate amount of the monthly premium increases provided under paragraph (2) for previous years for all enrollees over the total of the benefits and administrative costs which the Secretary determines were paid from the Federal Supplementary Medical Insurance Trust Fund for covered outpatient drugs dispensed and related administrative costs incurred in such previous years for all such enrollees.

"(2) Subject to paragraph (3), notwithstanding any other provision of this section (except as provided in subsections (b) and (f)), the monthly premium of each individual enrolled under this part for each month in a year after December 1987 shall be increased by the monthly actuarial rate determined according to paragraph (1) for that year; except that if the increase determined under this paragraph is not a multiple of 10 cents, it shall be rounded to the nearest multiple of 10 cents.

"(3) The increase in monthly premium under paragraph (2) for each month in—

"(A) 1988 may not exceed $0.30,
"(B) 1989 may not exceed $3.20,
"(C) 1990 may not exceed $4.90, and
"(D) a subsequent year may not exceed 120 percent of the monthly premium increase provided under paragraph (2) for months in the preceding year.".

(e) USE OF CARRIERS IN ADMINISTRATION.—

(1) ADDITIONAL FUNCTIONS OF CARRIERS.—Section 1842(b)(3) (42 U.S.C. 1395u(b)(3)), as amended by section 201(c), is amended—

(A) by striking "and" at the end of subparagraph (H),
(B) by adding "and" at the end of subparagraph (I), and
(C) by inserting after subparagraph (I) the following new subparagraph:

"(J) if it makes determinations or payments with respect to covered outpatient drugs, will—

"(i) offer, at the option of participating pharmacies, to receive requests for payments for such drugs through electronic communciations, and

"(ii) respond to requests by participating pharmacies as to whether or not an individual has met the deductible requirement of section 1833(m)(1)(A) for a year;".

(2) USE OF REGIONAL CARRIERS.—Section 1842(b)(2) is amended by adding at the end the following new sentence: "With respect to carrying out functions relating to payment for the Secretary may enter into contracts with carriers under this section to perform such functions on a regional basis.".

(f) MODIFICATION OF HMO/CMP RISK-SHARING CONTRACTS.—

(1) COUNTING OF EXPENSES BEFORE ENROLLMENT.—Section 1876(c) (42 U.S.C. 1395mm(c)) is amended by adding at the end the following new paragraph:

"(8) In the case of an individual who enrolls as a member of an eligible organization under this section after January 1 of a year, the organization must take into account, in computing the expenses incurred for covered outpatient drugs for purposes of meeting the deductible under section 1833(m)(1)(A) for the year, expenses incurred for covered outpatient drugs during the year while the individual was entitled to benefits under part B but before the individual so enrolled.".

(2) ADJUSTMENT OF AAPCC AND CONTRACTS.—The Secretary of Health and Human Services shall—

(A) in estimating the adjusted average per capita cost under section 1876(a) of the Social Security Act for portions of contract years occurring after December 31, 1988, take into account the amendments made by this section, and

(B) require eligible organizations with risk-sharing contracts under such section to make appropriate adjustments in the terms of their agreements with medicare beneficiaries to take into account such amendments.

(g) CONFORMING AMENDMENTS.—

(1) Section 1844(a) (42 U.S.C. 1395w(a)(1)) is amended by adding at the end the following:

"In computing the amount of aggregate premiums and premiums per enrollee under paragraph (1), there shall not be taken into account premiums attributable to section 1839(g).".

(2) The first sentence of section 1866(a)(2)(A)(i) (42 U.S.C. 1395cc(a)(2)(A)(i)) is amended by inserting "the amount of any deduction imposed pursuant to section 1833(m)(1) with respect to covered outpatient drugs" after "items and services by such provider)".

(3) Section 1905(p) (42 U.S.C. 1396d(p)) is amended—

(A) in paragraph (3)(C) (as subsequently amended by section 208(d)(2) of this Act), by inserting "and, subject to paragraph (4), the annual deductible under section 1833(m)(1)" after "1833(b)"; and

(B) by adding at the end the following new paragraph:

"(4) Instead of providing to qualified medicare beneficiaries, under paragraph (3)(C), medicare cost-sharing with respect to the annual deductible for covered outpatient drugs under section 1833(m)(1), a State may provide to such beneficiaries, before charges for covered outpatient drugs for a year reach such deductible amount, benefits for prescribed drugs in the same amount, duration, and scope as the benefits made available under the State plan for individuals described in subsection (a)(10)(A)(i).".

(h) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall apply to covered outpatient drugs dispensed on or after January 1, 1989.

(2) PREMIUMS—The amendments made by subsection (d) and (g)(1) shall apply to premiums for months beginning with January 1988.

(3) CARRIERS.—The amendments made by this subsection (e) shall take effect on the date of the enactment of this Act.

(4) HMO/CMP ENROLLMENTS.—The amendment made by subsection (f)(1) shall apply to enrollments effected on or after January 1, 1989.

(5) MEDICAID CHANGES.—(A) The amendments made by subsection (g)(3) apply (except as provided in subparagraph (B)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1988, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date, with respect to medical assistance for—

(i) monthly premiums under title XVIII of such Act for months beginning with July 1988, and

(ii) covered outpatient drugs dispensed on or after January 1, 1989.

(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by subsection (g)(3), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first session of the

State legislature that begins after the date of the enactment of this Act.

SEC. 203. IN-HOME CARE FOR CERTAIN CHRONICALLY DEPENDENT INDIVIDUALS.

(a) IN GENERAL.—Section 1832(a) (42 U.S.C. 1395k(a)) is amended—

(1) by amending subparagraph (A) of paragraph (2) to read as follows:

"(A)(i) home health services, and (ii) subject to section 1839(h)(4), in-home care for a chronically dependent individual for up to 120 hours in any calendar year;"; and

(2) by adding at the end the following new sentence:

"In the case of in-home care (described in paragraph (2)(A)(ii)) provided to a chronically dependent individual on any day, such care provided for 3 hours or less on the day shall be counted (for purposes of the limitation in such paragraph) as 3 hours of such care.".

(b) IN-HOME CARE FOR CHRONICALLY DEPENDENT INDIVIDUAL DEFINED.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

"In-Home Care; Chronically Dependent Individual

"(ff)(1) The term 'in-home care' means the following items and services furnished, under the supervision of a registered professional nurse, to a chronically dependent individual (as defined in paragraph (2)) by a home health agency or by others under arrangements with them made by such agency in a place of residence used as such individual's home:

"(A) Services of a homemaker/home health aide (who has successfully completed a training program approved by the Secretary).

"(B) Personal care services.

"(C) Nursing care provided by a licensed professional nurse.

"(2) The term 'chronically dependent individual' means an individual who—

"(A) is dependent on a daily basis on a primary caregiver who is living with the individual and is assisting the individual without monetary compensation in the performance of at least 2 of the activities of daily living (described in paragraph (3)), and

"(B) without such assistance could not perform such activities of daily living.

"(3) The 'activities of daily living', referred to in paragraph (2), are as follows:

"(i) Eating.

"(ii) Bathing.

"(iii) Dressing.

"(iv) Toileting.

"(v) Transferring in and out of a bed or in and out of a chair.".

(c) PAYMENT.—Section 1833(a) (42 U.S.C. 1395l(a)) is amended—

(1) in paragraph (2), by inserting "(A)(ii)," after "subparagraphs" the first place it appears,

(2) in paragraph (3), by striking "(D)" and inserting "(A)(ii), (D),", and

(3) by adding at the end the following:

"Payment for in-home care for chronically dependent individuals shall be paid on the basis of an hour of such care provided.".

(d) CERTIFICATION.—Section 1835(a)(2) (42 U.S.C. 1395n(a)(2)) is amended—

(1) by striking "and" at the end of subparagraph (D);

(2) by striking the period at the end of subparagraph (E) and inserting in lieu thereof "; and"; and

(3) by inserting after subparagraph (E) the following new subparagraph:

"(F) in the case of in-home care provided to a chronically dependent individual during a 12-month period, the individual was a chronically dependent individual during the 3-month period immediately preceding the beginning of the 12-month period.".

(e) ADDITIONAL PREMIUM FOR IN-HOME CARE.—Section 1839 (42 U.S.C. 1395r), as amended by section 202(d), is amended—

(1) in the second sentence of subsection (a)(1), by inserting "and costs relating to in-home care, as defined in section 1861(ff)(1)" after "covered outpatient drugs";

(2) in subsection (a)(2), by striking "and (g)" and inserting "(g), and (h)";

(3) in subsection (a)(3), by striking "and (g)" and inserting ", (g), and (h)";

(4) in the second sentence of subsection (a)(4), by inserting "and costs relating to in-home care, as defined in section 1861(ff)(1)" after "covered outpatient drugs"; and

(5) by adding at the end the following new subsection:

"(h)(1)(A) The Secretary shall, during September of 1988 and of each year thereafter, determine a monthly actuarial rate for in-home care (as defined in section 1861(ff)(1)) which shall be applicable for the succeeding calendar year.

"(B) Such actuarial rate shall be the amount the Secretary estimates to be necessary so that the aggregate amount for such calendar year with respect to enrollees will equal 100 percent of the total of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for in-home care provided and related administrative costs incurred in such calendar year with respect to such enrollees.

"(C) In establishing the monthly actuarial rate under this paragraph for each year (after 1990), the Secretary shall take into account any net surplus or deficit of the aggregate amount of the monthly premium increases provided under paragraph (2) for previous years for all enrollees over the total of the benefits and administrative costs which the Secretary determines were paid from the Federal Supplementary Medical Insurance Trust Fund for in-home care provided and related administrative costs incurred in such previous years for all such enrollees.

"(2) Subject to paragraph (3), notwithstanding any other provision of this section (except as provided in subsections (b) and (f)), the monthly premium of each individual enrolled under this part for each month in a year after December 1988 shall be increased by

the monthly actuarial rate determined according to paragraph (1) for that year; except that if the increase determined under this paragraph is not a multiple of 10 cents, it shall be rounded to the nearest multiple of 10 cents.

"(3) The increase in monthly premium under paragraph (2) for each month in—

"(A) 1989 may not exceed $0.40,

"(B) 1990 may not exceed $0.70, and

"(C) a subsequent year may not exceed 120 percent of the monthly premium increase provided under paragraph (2) for months in the preceding year.

"(4) If the monthly actuarial rate determined under paragraph (1) for a year (after 1990) exceeds 120 percent of the monthly premium increase provided under paragraph (2) for months in the preceding year, the Secretary shall decrease the maximum number of hours of in-home care under section 1832(a)(2)(A)(ii) in that year (and only in that year) by such an amount as will assure that—

"(A) the aggregate amount of the monthly premium increase provided under this subsection for the year for all enrollees,

is equal to—

"(B) the total of the benefits and administrative costs which the Secretary estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for in-home care provided and related administrative costs incurred in such year for all such enrollees.".

(f) STANDARDS FOR UTILIZATION.—

(1) Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(A) in paragraph (1)—

(i) in subparagraph (A), by striking "subparagraphs (B), (C), or (D)" and inserting "a succeeding subparagraph of this paragraph",

(ii) by striking "and" at the end of subparagraph (D),

(iii) by adding "and" at the end of subparagraph (E), and

(iv) by adding at the end the following new subparagraph:

"(F) in the case of in-home care for chronically dependent individuals, which is not reasonable and necessary to assure the health and condition of the individual is maintained in the individual's noninstitutional residence;"; and

(B) in paragraph (6), by inserting "and except, in the case of in-home care, as is otherwise permitted under paragraph (1)(F)" after "paragraph (1)(C)".

(2) The Secretary of Health and Human Services shall take appropriate efforts to assure the quality, and provide for appropriate utilization of, in-home care for chronically dependent individuals under the amendments made by this section.

(g) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1989; except that the amendments made by subsection (e) shall apply to premiums for months beginning with January 1989.

(h) STUDY OF ALTERNATIVE OUT-OF-HOME SERVICES.—The Secretary of Health and Human Services shall study, and report to Con-

gress, not later than 18 months after the date of the enactment of this Act, on the advisability of providing, to chronically dependent individuals eligible for in-home care under the amendments made by this section, out-of-home services (such as adult day care services or nursing facility services) as alternative services to in-home care.

(i) STUDY OF IN-HOME CARE.—The Secretary shall study, and report to Congress, not later than January 1, 1991, on the extent of use, cost, and effectiveness of in-home care provided to chronically dependent individuals under the amendments made by this section.

SEC. 204. EXTENDING HOME HEALTH SERVICES.

(a) COVERAGE.—Section 1861(m) (42 U.S.C. 1395x(m)) is amended by adding at the end the following new sentence: "For purposes of paragraphs (1) and (4) and sections 1814(a)(2)(C) and 1835(a)(2)(A), nursing care and home health aide services shall be considered to be provided or needed on an 'intermittent' basis if they are provided or needed less than 7 days each week and, in the case they are provided or needed for 7 days each week, if they are provided or needed for an initial period of up to 35 consecutive days, and for a subsequent period based on a physician certification of exceptional circumstances requiring such services on such a basis.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to services furnished on or after January 1, 1989.

SEC. 205. INCREASE IN MAXIMUM PAYMENT ALLOWED FOR OUTPATIENT MENTAL HEALTH SERVICES.

(a) IN GENERAL.—Section 1833(c) (42 U.S.C. 1395l(c)) is amended—

(1) in paragraph (1), by striking "$312.50" and inserting "the amount specified in paragraph (2) for that year";

(2) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B);

(3) by inserting "(1)" after "(c)"; and

(4) by adding at the end the following new paragraph:

"(2) The amount specified in this paragraph for 1989 is $1,250. The amount specified in this paragraph for each succeeding year is the amount specified in this paragraph for the preceding year increased by the percentage increase in the MEI (as defined in section 1842(b)(4)(E)(ii)) for the year involved. If any amount determined under the previous sentence is not a multiple of $10, it shall be rounded to the nearest multiple of $10.".

(b) CONFORMING AMENDMENTS.—(1) Section 1833(f), as inserted by section 201 of this Act, is amended by adding at the end the following new paragraph:

"(5) In applying paragraphs (1) and (2), the amount specified in subsection (c)(2) is deemed to be $312.50.".

(2) Section 1833(c) (42 U.S.C. 1395l(c)), as amended by subsection (a), is further amended by adding at the end the following new paragraph:

"(3) In this subsection, the term 'treatment' shall not be construed as including medical management visits.".

(3) The second sentence of section 1866(a)(2)(A) (42 U.S.C. 1395cc(a)(2)(A)) is amended by striking "1833(c)" and inserting "1833(c)(1)".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to expenses incurred for services furnished on or after January 1, 1989.

SEC. 206. COVERAGE OF INFLUENZA VACCINE AND ITS ADMINISTRATION.

(a) IN GENERAL.—Section 1861(s)(10)(A) (42 U.S.C. 1395x(a)(10)(A)) is amended by inserting before the semicolon the following: "and influenza vaccine and its administration".

(b) ADDITIONAL PREMIUM FOR INFLUENZA VACCINE.—Section 1839 (42 U.S.C. 1395r), as amended by sections 202(d) and 203(e), is amended—

(1) in the second sentence of subsection (a)(1)—

(A) by striking "and costs" and inserting ", costs", and

(B) by inserting "and costs relating to influenza vaccine and its administration" after "section 1861(ff)(1)";

(2) in subsection (a)(2), by striking "and (h)" and inserting "(h), and (i)";

(3) in subsection (a)(3), by striking "and (h)" and inserting "(h), and (i)";

(4) in the second sentence of subsection (a)(4)—

(A) by striking "and costs" and inserting ", costs", and

(B) by inserting "and costs relating to influenza vaccine and its administration" after "section 1861(ff)(1)"; and

(5) by adding at the end the following new subsection:

"(i)(1) The Secretary shall, during September of 1988 and of each year thereafter, determine a monthly actuarial rate for influenza vaccine and its administration which shall be applicable for the succeeding calendar year. Such actuarial rate shall be the amount the Secretary estimates to be necessary so that the aggregate amount for such calendar year with respect to enrollees will equal 100 percent of the total of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for influenza vaccine and related administrative costs incurred in such calendar year with respect to such enrollees.

"(2) Notwithstanding any other provision of this section (except as provided in subsections (b) and (f)), the monthly premium of each individual enrolled under this part for each month in a year after December 1988 shall be increased by the monthly actuarial rate determined according to paragraph (1) for that year; except that if the increase determined under this paragraph is not a multiple of 10 cents, it shall be rounded to the nearest multiple of 10 cents.".

(c) EFFECTIVE DATES.—The amendment made by subsection (a) shall apply to influenza vaccine administered on or after January 1, 1989, and the amendments made by subsection (b) shall apply to premiums for months beginning with January 1989.

SEC. 207. MAILING OF NOTICE OF MEDICARE BENEFITS AND PARTICIPATING PHYSICIAN DIRECTORIES.

(a) DISTRIBUTION OF NOTICE OF MEDICARE BENEFITS.—Title XVIII is amended by inserting after section 1803 the following new section:

"NOTICE OF MEDICARE BENEFITS

"SEC. 1804. (a) The Secretary shall distribute annually a notice containing—

"(1) a clear, simple explanation of the benefits available under this title and health care services for which benefits are not available under this title, and

"(2) a description of the limited benefits for long-term care services available under this title and generally available under State plans approved under title XIX.

Such notice shall be mailed annually to individuals entitled to benefits under part A or part B of this title.

"(b) There are authorized to be appropriated in equal proportions from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund such sums as may be required to provide for the annual publication and distribution of the notice described in subsection (a).".

(b) DISTRIBUTION OF PARTICIPATING PHYSICIAN DIRECTORIES.—The second sentence of section 1842(h)(6) (42 U.S.C. 1395u(h)(6)) is amended by inserting after "that area" the following: "and to each individual enrolled under this part and residing in that area".

(c) EFFECTIVE DATES.—

(1) The Secretary of Health and Human Services shall first distribute the notice required by the amendment made by subsection (a) not later than January 31, 1988, or, if later, 3 months after the date of the enactment of this Act.

(2) The amendment made by subsection (b) shall first apply to directories for 1988.

SEC. 208. REQUIRING MEDICAID BUY-IN OF PREMIUMS AND COST-SHARING FOR POOR MEDICARE BENEFICIARIES.

(a) REQUIREMENT.—(1) Section 1902(a)(10)(E) (42 U.S.C. 1396a(a)(10)(E)) is amended by striking "at the option of a State, but".

(2) Section 1905(p)(1)(B) (42 U.S.C. 1396d(p)(1)(B)) is amended by striking "and the election of the State".

(b) SETTING INCOME STANDARD AT 100 PERCENT OF POVERTY LEVEL.—Section 1905(p)(2)(A) (42 U.S.C. 1396d(p)(2)(A)) is amended by striking "may not exceed a percentage (not more than 100 percent) of the nonfarm" and inserting "shall be 100 percent of the".

(c) RESOURCE STANDARD.—Section 1905(p) (42 U.S.C. 1396d(p)) is amended—

(1) in paragraph (1)(C), by striking "(2)(A)" and inserting "(2)";

(2) in paragraph (1)(D), by striking "(except as provided in paragraph (2)(B))" and inserting "twice"; and

(3) in paragraph (2)—

(A) in subparagraph (A), by striking "(2)(A)" and inserting "(2)", and

(B) by striking subparagraph (B).

(d) MEDICARE COVERAGE.—Section 1905(p)(3) (42 U.S.C. 1396d(p)(3)) is amended—

(1) in subparagraph (A), by striking "under part B and (if applicable) under section 1818" and inserting "under title XVIII

(including under part B and, if applicable, under section 1818)"; and

(2) by amending subparagraphs (B) and (C) to read as follows:

"(B) Coinsurance under title XVIII (including coinsurance described in section 1813).

"(C) Deductibles established under title XVIII (including those described in section 1813 and 1833(b)).".

(e) CONFORMING AMENDMENTS.—(1) Section 1902(a)(10)(A)(i) (42 U.S.C. 1396a(a)(10)(A)(i)) is amended by adding after and below subclause (III) the following:

"and, to the extent required under subsection (m)(3), some or all of the individuals described in subsection (l)(1);".

(2) Section 1843 (42 U.S.C. 1395v) is amended by inserting "or after 1987" in subsections (a), (g)(1), and (h)(1) after "during 1981".

(f) TECHNICAL AMENDMENT.—Effective as though included in the enactment of the Omnibus Budget Reconciliation Act of 1986, paragraph (2) of section 9403(g) of such Act is amended to read as follows:

"(2) PAYMENT OF MEDICARE COST-SHARING.—Section 1903(a)(1) of such Act (42 U.S.C. 1396b(a)(1)) is amended by inserting 'including expenditures for medicare cost-sharing and' before 'including expenditures.'."

(g) TREATMENT OF CERTAIN STATES.—

(1) STATES OPERATING UNDER DEMONSTRATION PROJECTS.—In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115 of the Social Security Act, the Secretary of Health and Human Services shall require the State to meet the requirement of section 1902(a)(10)(E) of the Social Security Act in same manner as the State would be required to meet such requirement if the State had in effect a plan approved under title XIX of such Act.

(2) COMMONWEALTHS AND TERRITORIES.—Section 1905(p) (42 U.S.C. 1396d(p)), as amended by section 202(g)(3)(B), is amended by adding at the end the following new paragraph:

"(5) Notwithstanding any other provision of this title, in the case of a State (other than the 50 States and the District of Columbia)—

"(A) the requirement stated in section 1902(a)(10)(E) shall be optional, and

"(B) for purposes of paragraph (2)(A), the State may substitute for 100 percent any lesser percentage.".

(h) EFFECTIVE DATE.—(1) The amendments made by this section apply (except as provided in subsection (f) and under paragraph (2)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1988, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date, with respect to medical assistance for—

(A) monthly premiums under title XVIII of such Act for months beginning with July 1988, and

(B) items and services furnished on and after July 1, 1988.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than

legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first session of the State legislature that begins after the date of the enactment of this Act.

SEC. 209. ADJUSTMENT IN MEDICARE PART B PREMIUM.

(a) TRANSITIONAL ADJUSTMENTS IN 1990 AND 1991.—Section 1839(e) (42 U.S.C. 1395r(e)) is amended by adding at the end the following new paragraph:

"(3)(A) Notwithstanding the provisions of subsection (a), but subject to the provisions of subsections (g), (h), and (i) the monthly premium for each individual enrolled under this part for each month—

"(i) in 1990 shall be $1.00 greater than the amount otherwise determined under subsection (a), and

"(ii) in 1991 shall be 40 cents greater than the amount otherwise determined under subsection (a).

Any increases in premium amounts taking effect under this paragraph for months in a year shall be taken into account for purposes of determining increases in each subsequent year under subsection (a)(3).

"(B) Subparagraph (A) does not apply to premiums determined under paragraph (4) or (5).".

(b) PART B PREMIUM FOR RESIDENTS OF U.S. COMMONWEALTHS AND TERRITORIES.—Such section is further amended by adding at the end the following new paragraph:

"(4)(A) Notwithstanding the provisions of subsection (a), but subject to subsections (g), (h), and (i), in the case of an individual who is a resident of a commonwealth or territory during a month—

"(i) in 1988 or 1989, the monthly premium otherwise determined for the individual under paragraph (1) or subsection (a)(3), respectively, shall be increased by the amount described in subparagraph (B) for that month; or

"(ii) in a subsequent year, the monthly premium which shall apply shall be the amount described in subparagraph (C) for that month.

"(B) The amount described in this subparagraph for a month in 1988 or 1989 for an individual residing in a particular commonwealth or territory is 1/12th of the product of—

"(i) the average, per capita additional benefits (and related administrative costs), as determined by the Secretary during September of the previous year, that will be payable under this title during the year by reason of the amendments made by the Medicare Catastrophic Protection Act of 1987 (other than sections 202, 203, and 206 thereof); and

"(ii) the ratio (determined by the Secretary for that commonwealth or territory during September 1987) of—

"(I) the per capita actuarial value of the benefits under this title for residents of the commonwealth or territory who are entitled to benefits under both part A and this part, to

"(II) the per capita actuarial value of the benefits under this title for residents of the United States who are entitled to benefits under both part A and this part.

"(C) The amount described in this subparagraph for a month in—

"(i) 1990, is the sum of—

"(I) the monthly premium established under subsection (a)(3) for months in 1989, and

"(II) the amount described in subparagraph (B) for months in 1989,

increased by the premium percentage increase (as defined in subparagraph (E)(ii)) for 1990; or

"(ii) a succeeding year is the amount described in this subparagraph for months in the previous year increased by the premium increase percentage for that succeeding year.

"(D) If any amount determined under the previous provisions of this subparagraph is not a multiple of 10 cents, the Secretary shall round the amount to the nearest multiple of 10 cents.

"(E) In this paragraph:

"(i) The term 'commonwealth or territory' means Puerto Rico, the Virgin Islands, Guam, American Samoa, or the Northern Mariana Islands.

"(ii) The term 'percentage premium increase', for a year, means the percentage determined under subsection (a)(3)(B) in the previous year.".

(c) PART B PREMIUM FOR INDIVIDUALS ENROLLED UNDER PART B BUT NOT ENTITLED TO BENEFITS UNDER PART A.—Such section is further amended by adding at the end the following new paragraph:

"(5)(A) Notwithstanding the provisions of subsection (a), but subject to subsections (g), (h), and (i), in the case of a part B only individual (as defined in subparagraph (E)) during a month—

"(i) in 1989, the monthly premium otherwise determined for the individual under subsection (a)(3) shall be increased by the amount described in subparagraph (B); or

"(ii) in a subsequent year, the monthly premium which shall apply shall be the amount described in subparagraph (C) for that month.

"(B) The amount described in this subparagraph is 1/12th of the average, per capita additional benefits (and related administrative costs) that the Secretary estimates (during September of 1988) will be payable under this part during 1989 by reason of the amendments made by the Medicare Catastrophic Protection Act of 1987 (other than sections 202, 203, and 206 thereof).

"(C) The amount described in this subparagraph for a month—

"(i) in 1990, is the sum of—

"(I) the monthly premium established under subsection (a)(3) for months in 1989, and

"(II) the amount described in subparagraph (B),

increased by the premium percentage increase (as defined in paragraph (4)(E)(ii)) for 1990; or

"(ii) in a succeeding year is the amount described in this subparagraph for months in the previous year increased by the premium increase percentage (as so defined) for that succeeding year.

"(D) If any amount determined under the previous provisions of this paragraph is not a multiple of 10 cents, the Secretary shall round the amount to the nearest multiple of 10 cents.

"(E) In this paragraph the term 'part B only individual' means, with respect to a premium for a month, an individual who—

"(i) is not a resident of a commonwealth or territory (as defined in paragraph (4)(E)(i)) during the month,

"(ii) is entitled to benefits under this part, and

"(iii) is not entitled to (or, on application without payment of an additional premium, would not be entitled to) benefits under part A.".

(d) CONFORMING AMENDMENTS.—

(1) Section 1839(b) (42 U.S.C. 1395r(b)) is amended by striking "determined under subsection (a) or (e)" and inserting "otherwise determined under this section (without regard to subsection (f))".

(2) Section 1839 (42 U.S.C. 1395r), as amended by sections 202(d), 203(e), and 206(b), is amended—

(A) in the second sentence of subsection (a)(1)—

(i) by striking "and costs" and inserting ", costs", and

(ii) by inserting ", and costs attributable to section 1812(f)" after "influenza vaccine and its administration"; and

(B) in the second sentence of subsection (a)(4)—

(i) by striking "and costs" and inserting ", costs", and

(ii) by inserting ", and costs attributable to section 1812(f)" after "influenza vaccine and its administration".

(3) The last sentence of section 1844(a) (42 U.S.C. 1395w(a)(1)), as added by section 202(g)(1), is amended by inserting before the period at the end the following: "such premiums shall be computed as though the clause '(other than costs attributable to section 1812(f))' was deleted from paragraphs (1) and (4) of section 1839(a)".

(e) EFFECTIVE DATES.—

(1) The amendments made by subsection (a) shall apply to monthly premiums for months beginning with January 1990.

(2) The amendments made by subsection (b) shall apply to monthly premiums for months beginning with January 1988.

(3) The amendment made by subsections (c) and (d) shall apply to monthly premiums for months beginning with January 1989.

SEC. 210. CHANGES IN CERTIFICATION OF MEDICARE SUPPLEMENTAL HEALTH INSURANCE POLICIES.

(a) ESTABLISHMENT OF NEW MEDIGAP STANDARDS.—

(1) RECOMMENDED CHANGES.—The Secretary of Health and Human Services shall report to Congress, not later than 150 days after the date of the enactment of this Act, on changes that should be made in the requirements of subsection (c) of section 1882 of the Social Security Act for certification of medicare supplemental policies to take into account both the

amendments made by this Act, and by any other pertinent Acts enacted by the first session of the 100th Congress, and any recommendations developed by the National Association of Insurance Commissioners.

(2) CONGRESSIONAL ACTION.—It is the sense of Congress that—

(A) Congress will promptly act on such recommendations and provide for appropriate changes in the requirements of subsection (c) of that section, and

(B) States will be expected to adjust their laws in a timely manner to comply with the changes in such requirements.

(b) REQUIRED MAILING OF NOTICE.—

(1) IN GENERAL.—Section 1882(b) (42 U.S.C. 1395ss(b)) is amended by adding at the end the following new paragraph:

"(3) Notwithstanding paragraph (1), in the case of a medicare supplemental policy offered in a State and in effect on January 1, 1988, the policy shall not be deemed to meet the standards and requirements set forth in subsection (c), unless each individual who is entitled to benefits under this title and is a policyholder under such policy on January 1, 1988, is sent a letter by not later than January 31, 1988, that explains—

"(A) the improved benefits under this title contained in legislation enacted by the first session of the 100th Congress, and

"(B) how these improvements affect the benefits contained in the policies and the premium for the policy.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to medicare supplemental policies as of February 1, 1988.

(c) REQUIRED SUBMISSION OF ADVERTISING.—

(1) IN GENERAL.—Section 1882(b) is further amended by adding after paragraph (3) the following new paragraph:

"(4) Notwithstanding paragraph (1), a medicare supplemental policy offered in a State shall not be deemed to meet the standards and requirements set forth in subsection (c), with respect to a advertisment (whether through written, radio, or television medium) used (or, at a State's option, to be used) for the policy in the State, unless the entity issuing the policy provides a copy of each advertisement to the Commissioner of Insurance (or comparable officer identified by the Secretary) of that State for his or her review in accordance with State law.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to medicare supplemental policies as of January 1, 1988, with respect to advertising used on or after such date.

(d) TRANSITION FOR CURRENT POLICIES.—Notwithstanding any other provision of law, during the period beginning on January 1, 1988, and ending on December 31, 1988, no penalty may be imposed under subparagraph (A) of section 1882(d)(3) of the Social Security Act with respect to a medicare supplemental policy which—

(1) is being offered as of (and has been offered before) the date of the enactment of this Act, and

(2) would not substantially duplicate health benefits to which an individual is otherwise entitled under title XVIII of such Act but for the amendments made by this Act.

SEC. 211. EXTENSION OF SOCIAL HMO DEMONSTRATION PROJECT.

(a) THROUGH SEPTEMBER 30, 1992.—The Secretary of Health and Human Services shall extend without interruption, through September 30, 1992, the approval of waivers granted under subsection (a) of section 2355 of the Deficit Reduction Act of 1984 for the demonstration project described in subsection (b) of that section, subject to the terms and conditions (other than duration of the project) established under that section (as amended by subsection (b)).

(b) EXTENSION OF RISK.—Section 2355(b)(5) of the Deficit Reduction Act of 1984 is amended by inserting "and in succeeding years" after "third year".

(c) INTERIM REPORT.—Section 2355(d)(2) of the Deficit Reduction Act of 1984 is amended by striking "final" and inserting "interim".

(d) FINAL REPORT.—The Secretary shall submit a final report to the Congress on the project referred to in subsection (a) not later than March 31, 1993.

SEC. 212. STUDY ON COMPREHENSIVE MEDICAL COVERAGE UNDER THE MEDICARE PROGRAM.

(a) IN GENERAL.—The Comptroller General shall conduct a study to assess the need for, and cost of, including each of the following services in the medicare program for medicare beneficiaries:

(1) ANNUAL PREVENTIVE CARE VISITS.—Diagnostic procedures performed during an annual physician examination, including (as medically appropriate by sex) a routine Papanicolaou test for diagnosis of uterine cancer, blood pressure test, blood test for cholesterol levels, colorectal exam, and a mammogram.

(2) ROUTINE EYE CARE.—An annual vision examination and the dispensing of prescription eyeglasses.

(3) DENTAL CARE.—Dental services, including an annual dental examination and cleaning, tooth extractions, simple restorations, services required for dentures, surgical preparation of endentulous ridges, periodontal therapy, and endodontics.

(4) HEARING CARE.—Biannual hearing threshold testing and hearing aids for those with a significant hearing loss.

(5) LONG-TERM CARE SERVICES.—Comprehensive long-term care services (including adult day care services, intermediate care facility services, home- and community-based services, outpatient drug therapy, and respite care) provided on a case-managed basis in the environment of least restriction, where approved and regularly recertified by a geriatric assessment team.

(6) PRESCRIPTION DRUGS AND BIOLOGICALS.—Prescription drugs and biologicals.

(b) COST DETERMINATION.—The Comptroller General shall make separate determinations of the costs of each of the services described in subsection (a) on the basis of fee-for-service reimbursement and on the basis of a comprehensive capitation payment arrangement. Such costs shall be determined for fiscal year 1988 and each of the succeeding 4 fiscal years.

(c) REPORT.—The Comptroller General shall report to the Congress on the results of the study under this section not later than 6 months after the date of the enactment of this Act.

SEC. 213. RESEARCH ON LONG-TERM CARE SERVICES FOR MEDICARE BENEFICIARIES.

(a) IN GENERAL.—The Secretary of Health and Human Services, from the funds appropriated under subsection (b), shall provide for research on issues relating to the delivery and financing of long-term care services for medicare beneficiaries. Such research shall include research into at least the following areas:

(1) The financial characteristics of medicare beneficiaries who receive or need long-term care services, including whether such beneficiaries are eligible for medicaid benefits for such services.

(2) How the financial and other characteristics of medicare beneficiaries affect their utilization of institutional and noninstitutional long-term care services.

(3) How relatives of medicare beneficiaries are affected financially and in other ways because the beneficiaries require or receive long-term care services.

(4) The quality of long-term care services (in community-based and custodial settings) and how the provision of long-term care services may reduce expenditures for acute health care services.

(5) The effectiveness of, and need for, State and Federal consumer protections which assure adequate access to and protect the rights of medicare beneficiaries who are provided long-term care services (other than in a nursing facility).

(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, in equal parts from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, $5,000,000 for each of fiscal years 1988, 1989, 1990, 1991, and 1992, to carry out the research described in subsection (a).

(c) LONG-TERM CARE SERVICES DEFINED.—In this section, the term "long-term care services" includes nursing home care, home care, community-based services, and custodial care.

SEC. 214. PROTECTION OF INCOME AND RESOURCES OF COUPLE FOR MAINTENANCE OF COMMUNITY SPOUSE.

(a) IN GENERAL.—Title XIX is amended—

(1) by redesignating section 1921 as section 1922, and

(2) by inserting after section 1920 the following new section:

"TREATMENT OF INCOME AND RESOURCES FOR CERTAIN INSTITUTIONALIZED SPOUSES

"SEC. 1921. (a) SPECIAL TREATMENT FOR INSTITUTIONALIZED SPOUSES.—

"(1) SUPERSEDES OTHER PROVISIONS.—In determining the eligibility for medical assistance of an institutionalized spouse (as defined in subsection (g)(1)), the provisions of this section supersede any other provision of this title (including sections 1902(a)(17) and 1902(f)) which is inconsistent with them.

"(2) NO COMPARABLE TREATMENT REQUIRED.—Any different treatment provided under this section for institutionalized spouses shall not, by reason of paragraph (10) or (17) of section 1902(a), require such treatment for other individuals.

"(3) DOES NOT AFFECT CERTAIN DETERMINATIONS.—Except as this section specifically provides, this section does not apply to—

"(A) the determination of what constitutes income or resources, or

"(B) the methodology and standards for determining and evaluating income and resources.

"(4) ELECTION TO USE OTHER RULES.—An institutionalized spouse may elect not to have this section (other than subsection (c)) apply but to have the spouse's resources and income determined under the law, practice, or policy of the plan (whether approved or not) in effect on March 1, 1987, except to the extent inconsistent with subsection (c).

"(5) APPLICATION IN CERTAIN STATES AND TERRITORIES.—

"(A) APPLICATION IN STATES OPERATING UNDER DEMONSTRATION PROJECTS.—In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115, the Secretary shall require the State to meet the requirements of this section in same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this title XIX.

"(B) NO APPLICATION IN COMMONWEALTHS AND TERRITORIES.—This section shall only apply to a State that is one of the 50 States or the District of Columbia.

"(b) RULES FOR TREATMENT OF INCOME.—

"(1) SEPARATE TREATMENT OF INCOME.—During any month in which an institutionalized spouse is in the institution, no income of the community spouse shall be deemed available to the institutionalized spouse.

"(2) ATTRIBUTION OF INCOME.—In determining the income of an institutionalized spouse or community spouse, except as otherwise provided in this section and regardless of any State laws relating to community property or the division of marital property, the following rules apply:

"(A) NON-TRUST PROPERTY.—Subject to subparagraphs (C) and (D), in the case of income not from a trust, unless the instrument providing the income otherwise specifically provides—

"(i) if payment of income is made solely in the name of the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;

"(ii) if payment of income is made in the names of the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them; and

"(iii) if payment of income is made in the names of the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each of the individuals named in equal proportional shares.

"(B) TRUST PROPERTY.—In the case of a trust—

"(i) except as provided in clause (ii), income shall be attributed in accordance with the provisions of this title (including sections 1902(a)(17) and 1902(k)), and

"(ii) unless the trust otherwise specifically provides—

"(I) if payment of income is made solely to the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;

"(II) if payment of income is made to both the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them; and

"(III) if payment of income is made to the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each of such individuals in equal proportional shares.

"(C) PROPERTY WITH NO INSTRUMENT.—In the case of income not from a trust in which there is no instrument establishing ownership, subject to subparagraph (D), one-half of the income shall be considered to be available to the institutionalized spouse and one-half to the community spouse.

"(D) REBUTTING OWNERSHIP.—The rules of subparagraphs (A) and (C) are superceded to the extent that an institutionalized spouse can establish, by a preponderance of the evidence, that the ownership interests in income are other than as provided under such subparagraphs.

"(c) RULES FOR TREATMENT OF RESOURCES.

"(1) COMPUTATION OF SPOUSAL SHARE AT TIME OF INSTITUTIONALIZATION.—There shall be computed (as of the beginning of a continuous period of institutionalization of the institutionalized spouse) a spousal share which is equal to one-half of the value of all the resources held by either the institutionalized spouse, community spouse, or both.

"(2) ATTRIBUTION OF RESOURCES AT TIME OF INITIAL ELIGIBILITY DETERMINATION.—In determining the resources of an institutionalized spouse at the time of application for benefits under this title, regardless of any State laws relating to community property or the division of marital property—

"(A) except as provided in subparagraph (B), all the resources held by either the institutionalized spouse, community spouse, or both, shall be considered to be available to the institutionalized spouse, and

"(B) resources held in the name of (or for the sole benefit of) the community spouse shall not be considered to be available to an institutionalized spouse, to the extent that the amount of such resources does not exceed the amount computed under subsection (e)(2)(A) (as of the time of application for benefits) or, if greater, the amount that a court has ordered to be retained by the community spouse for the support of the community spouse.

"(3) SEPARATE TREATMENT OF RESOURCES AFTER ELIGIBILITY FOR BENEFITS ESTABLISHED.—During the continuous period in which an institutionalized spouse is in an institution and after the month in which an institutionalized spouse is determined to be eligible for benefits under this title, no resources of the community spouse shall be deemed available to the institutionalized spouse.

"(4) RESOURCES DEFINED.—In this section, the term 'resources' does not include resources excluded under subsection (a) or (d) of section 1613 and does not include resources that would be excluded under section 1613(a)(2)(A) but for the limitation on total value described in such section.

"(c) PROTECTING INCOME FOR COMMUNITY SPOUSE.—

"(1) ALLOWANCES TO BE OFFSET FROM INCOME OF INSTITUTIONALIZED SPOUSE.—After an institutionalized spouse is determined to be eligible for medical assistance, in determining the amount of the spouse's income that is to be applied monthly to payment for the costs of care in the institution, there shall be deducted from the spouse's monthly income the following amounts in the following order:

"(A) A personal needs allowance that is reasonable in amount for clothing and other personal needs of the institutionalized spouse and which is not less than $25 per month.

"(B) A community spouse monthly income allowance (as defined in paragraph (2)), but only to the extent income of the institutionalized spouse is made available to (or for the benefit of) the community spouse.

"(C) A family allowance, for each family member, equal to at least one-third of the amount by which the amount described in paragraph (3)(A)(i) exceeds the amount of the monthly income of that family member.

"(D) Amounts for incurred expenses for medical or remedial care for the institutionalized spouse that are not subject to payment by a legally liable third party.

In subparagraph (C), the term 'family member' only includes minor or dependent children, dependent parents, or dependent siblings of the institutionalized or community spouse who are residing with the community spouse.

"(2) COMMUNITY SPOUSE MONTHLY INCOME ALLOWANCE DEFINED.—In this section (except as provided in paragraph (6)), the 'community spouse monthly income allowance' for a community spouse is an amount by which—

"(A) except as provided in paragraph (4), the minimum monthly maintenance needs allowance (established under and in accordance with paragraph (3)) for the spouse, exceeds

"(B) the amount of monthly income otherwise available to the community spouse (determined without regard to such an allowance).

"(3) ESTABLISHMENT OF MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—

"(A) IN GENERAL.—Each State shall establish a minimum monthly maintenance needs allowance for each com-

munity spouse which, subject to subparagraph (B), is equal to or exceeds—

"(i) 150 percent of 1/12 of the nonfarm income official poverty line (defined by the Office of Management and Budget and revised annually in accordance with sections 652 and 673(2) of the Omnibus Budget Reconciliation Act of 1981) for a family unit of 2 members; plus

"(ii) an excess shelter allowance (as defined in paragraph (5)); plus

"(iii) ½ of the amount by which the income available to the institutionalized spouse exceeds the sum of the amounts described in clauses (i) and (ii).

A revision of the official poverty line referred to in clause (i) shall apply to medical assistance furnished during and after the second calendar quarter that begins after the date of publication of the revision.

"(B) CAP ON MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—The minimum monthly maintenance needs allowance established under subparagraph (A) may not exceed $1,500 (subject to adjustment under subsection (f)).

"(4) NOTICE AND FAIR HEARING.—

"(A) NOTICE.—Upon—

"(i) a determination of eligibility for medical assistance of an institutionalized spouse, or

"(ii) a request by an institutionalized spouse (or community spouse or representative on the spouse's behalf),

each State shall notify the spouse of the amount of the community spouse monthly income allowance (described in paragraph (1)(B)), of the amount of any family allowances (described in paragraph (1)(C)), of the method for computing the amount of the community spouse resources allowance permitted under subsection (e), and of the spouse's right to a fair hearing under subparagraph (B) respecting the determination of the community spouse monthly income allowance.

"(B) FAIR HEARING.—If an institutionalized spouse is dissatisfied with a determination of—

"(i) the community spouse monthly income allowance because the amount of the minimum monthly maintenance needs allowance (established under paragraph (3)) is not adequate to support the community spouse without financial duress, or

"(ii) the amount of monthly income otherwise available to the community spouse (as applied under paragraph (2)(B)),

the institutionalized spouse is entitled to a fair hearing described in section 1902(a)(3) with respect to such determination. If the institutionalized spouse establishes that the minimum monthly maintenance needs allowance is not adequate to support the community spouse without financial duress, there shall be substituted, for the minimum monthly maintenance needs allowance in paragraph (2)(A),

an amount adequate to support the community spouse without financial duress.

"(5) EXCESS SHELTER ALLOWANCE DEFINED.—In paragraph (3)(A)(ii), the term 'excess shelter allowance' means, for a community spouse, the amount by which the sum of—

"(A) the spouse's expenses for mortgage payment (including principal, interest, taxes, and insurance and, in the case of a condominium or cooperative, required maintenance charge) or rent, and

"(B) the standard utility allowance (used by the State under section 5(e) of the Food Stamp Act of 1977) or, if the State does not use such an allowance, the spouse's actual utility expenses,

exceeds 30 percent of the amount described in paragraph (3)(A)(i), except that, in the case of a condominium or cooperative, for which a maintenance charge is included under subparagraph (A), any allowance under subparagraph (B) shall be reduced to the extent the maintenance charge includes utility expenses.

"(6) COURT ORDERED SUPPORT.—If a court has entered an order against an institutionalized spouse for monthly income for the support of the community spouse, the community spouse monthly income allowance for the spouse shall be not less than the amount of the monthly income so ordered.

"(e) PERMITTING TRANSFER OF RESOURCES TO COMMUNITY SPOUSE.—

"(1) IN GENERAL.—An institutionalized spouse may, without regard to section 1917, transfer to the community spouse (or to another for the sole benefit of the community spouse) an amount equal to the community spouse resource allowance (as defined in paragraph (2)), but only to the extent the resources of the institutionalized spouse are transferred to (or for the sole benefit of) the community spouse.

"(2) COMMUNITY SPOUSE RESOURCE ALLOWANCE DEFINED.—In paragraph (1), the 'community spouse resource allowance' for a community spouse is an amount (if any) by which—

"(A) the greater of—

"(i) $12,000 (subject to adjustment under subsection (f)), or

"(ii) the lesser of (I) the spousal share computed under subsection (c)(1), or (II) 4 times the amount described in clause (i), exceeds

"(B) the amount of the resources otherwise available to the community spouse (determined without regard to such an allowance).

"(3) TRANSFERS UNDER COURT ORDERS.—If a court has entered an order against an institutionalized spouse for the support of the community spouse, section 1917 shall not apply to amounts of resources transferred pursuant to such order for the support of the spouse of a family member (as defined in subsection (d)(1)).

"(f) INDEXING DOLLAR AMOUNTS.—For services furnished during a calendar year after 1988, the dollar amounts specified in subsections (d)(3)(B) and (e)(2)(A)(i) shall be increased by the same percent-

age as the percentage increase in the consumer price index for all urban consumers (all items; U.S. city average) between September 1987 and the September before the calendar year involved.

"(g) DEFINITIONS.—In this section:

"(1) The term 'institutionalized spouse' means an individual who—

"(A) is in a hospital, skilled nursing facility, or intermediate care facility, or who (at the option of the State) is described in section 1902(a)(10)(A)(ii)(VI), and

"(B) is married to a spouse who is not in a hospital, skilled nursing facility, or intermediate care facility;

but does not include any such individual who is not likely to meet the requirements of subparagraph (A) for at least 30 consecutive days.

"(2) The term 'community spouse' means the spouse of an institutionalized spouse.".

(b) TAKING INTO ACCOUNT CERTAIN TRANSFERS OF ASSETS.—Subsection (c) of section 1917 (42 U.S.C. 1396p) is amended to read as follows:

"(c)(1) In order to meet the requirements of this subsection (for purposes of section 1902(a)(49)(B)), the State plan must provide for a period of ineligibility in the case of an institutionalized individual (as defined in paragraph (3)) who, at any time during the 24-month period immediately before the individual's application for medical assistance under the State plan, disposed of resources for less than fair market value. The period of ineligibility shall begin with the month in which such resources were transferred and the number of months in such period shall be equal to (A) the total uncompensated value of the resources so transferred, divided by (B) the average cost, to a private patient at the time of the application, of nursing home care in the State or, at State option, in the community in which the individual is institutionalized.

"(2) An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that—

"(A) the resources transferred were a home and title to the home was transferred to the individual's spouse or child who is under age 21, or (with respect to State eligible to participate in the State program established under title XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1614;

"(B) the resources were transferred to (or to another for the sole benefit of) the community spouse, as defined in section 1921(g)(2);

"(C) a satisfactory showing is made to the State (in accordance with any regulations promulgated by the Secretary) that the individual intended to dispose of the resources either at fair market value, or for other valuable consideration; and

"(D) the State determines that denial of eligibility would work an undue hardship.

"(3) In this subsection, the term 'institutionalized individual' means an individual who—

"(A) is an inpatient in a skilled nursing facility, intermediate care facility, or other medical institution and

"(B) is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

"(4) A State may not provide for any period of ineligibility for an institutionalized individual due to transfer of resources for less than fair market value except in accordance with this subsection.".

(c) CONFORMING AMENDMENT.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(1) in paragraph (10)(C)(i)(III), by striking "the same" each place it appears and inserting "no more restrictive than the";

(2) by striking "and" at the end of paragraph (46);

(3) by striking out the period at the end of the paragraph (47) inserted by section 9407(a) of the Omnibus Budget Reconciliation Act of 1986 and inserting a semicolon;

(4) in the paragraph (47) added by section 11005(b) of the Anti-Drug Abuse Act of 1986, by redesignating such paragraph as paragraph (48), by transferring and inserting such paragraph immediately after paragraph (47), and by striking the period and inserting "; and";

(5) by inserting after paragraph (48) the following new paragraph:

"(49)(A) meet the requirements of section 1921 (relating to protection of community spouses), and (B) meet the requirement of section 1917(c) (relating to transfer of assets)."; and

(6) by adding at the end the following new sentence: "For purposes of paragraph (10), methodology is considered to be 'no more restrictive' if, using the methodology, additional individuals may be eligible for medical assistance and no individuals who are otherwise eligible are made ineligible for such assistance.".

(d) EFFECTIVE DATE.—(1) The amendments made by this section apply (except as provided under paragraphs (2) and (3)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after January 1, 1988, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

(3) The amendments made by subparagraphs (A) and (F) of subsection (c)(1) shall apply to medical assistance furnished on or after October 1, 1982.

SEC. 215. STUDY OF ADULT DAY CARE SERVICES.

(a) SURVEY OF CURRENT ADULT DAY CARE SERVICES.—The Secretary of Health and Human Services shall conduct a survey of adult day care services in the United States to collect information concerning—

(1) the scope of such services and the extent of their availability;

(2) the characteristics of entities providing such services;

(3) licensure, certification, and other quality standards that are applied to those providing such services;

(4) the cost and financing of such services; and

(5) the characteristics of the people who use such services.

(b) REPORT.—The Secretary shall report to Congress, by not later than 1 year after the date of the enactment of this Act, on the information collected in the survey. Based on such information, the Secretary shall include in the report recommendations concerning appropriate standards for coverage of adult day care services under medicare, including defining chronically dependent individuals, defining services included in adult day care services, establishing qualifications of providers of adult day care services, and establishing a reimbursement mechanism.

(c) ADULT DAY CARE SERVICES DEFINED.—In this section, the term "adult day care services" means medical or social services provided in an organized nonresidential setting to chronically impaired individuals who are not inpatients in a medical institution.

TITLE III—UNITED STATES BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE

SEC. 301. ESTABLISHMENT.

There is established a commission to be known as the United States Bipartisan Commission on Comprehensive Health Care (in this Act referred to as the "Commission").

SEC. 302. DUTIES.

(a) IN GENERAL.—The Commission shall—

(1) examine shortcomings in the current health care delivery and financing mechanisms that limit or prevent access of all individuals in the United States to comprehensive health care, and

(2) make specific recommendations to the Congress respecting Federal programs, policies, and financing needed to assure the availability of—

(A) comprehensive long-term care services for the elderly and disabled,

(B) comprehensive health care services for the elderly and disabled, and

(C) comprehensive health care services for all individuals in the United States.

(b) CONSIDERATIONS IN RECOMMENDATIONS.—In making its recommendations, the Commission shall consider—

(1) the amount and sources (consistent with principles of social insurance) of Federal funds to finance the needed services, including reallocations of existing Federal program funds, and

(2) the most efficient and effective manner of administering such programs.

(c) DEFINITIONS.—In this title:

(1) The term "comprehensive health care services" includes—

(A) inpatient hospital services (including mental health services);

(B) skilled nursing facility services, intermediate care facility services, home health services, and other long-term health care services;

(C) physician services and other outpatient health care services (including mental health services);

(D) periodic general physical examinations, eye examinations, hearing examinations, dental examinations, foot examinations, and other preventive health care services; and

(E) prescription drugs, eyeglasses, hearing aids, orthopedic equipment, and dentures (both complete and partial).

(2) The term "comprehensive long-term care services" includes custodial and noncustodial services in facilities, as well as home and community-based services.

SEC. 303. MEMBERSHIP.

(a) APPOINTMENT.—The Commission shall be composed of 15 members appointed as follows:

(1) The President shall appoint 3 members.

(2) The President Pro Tempore of the Senate shall appoint, after consultation with the minority leader of the Senate, 6 members, of whom not more than 4 may be of the same political party.

(3) The Speaker of the House of Representatives shall appoint, after consultation with the minority leader of the House of Representatives, 6 members of the House, of whom not more than 4 may be of the same policital party.

(b) CHAIRMAN AND VICE CHAIRMAN.—The Commission shall elect a chairman and vice chairman from among its members.

(c) VACANCIES.—Any vacancy in the membership of the Commission shall be filled in the manner in which the original appointment was made and shall not affect the power of the remaining members to execute the duties of the Commission.

(d) QUORUM.—A quorum shall consist of 8 members of the Commission, except that 4 members may conduct a hearing under section 305(a).

(e) MEETINGS.—The Commission shall meet at the call of its chairman or a majority of its members.

(f) COMPENSATION AND REIMBURSEMENT OF EXPENSES.—Members of the Commission are not entitled to receive compensation for service on the Commission. Members may be reimbursed for travel, subsistence, and other necessary expenses incurred in carrying out the duties of the Commission.

SEC. 304. STAFF AND CONSULTANTS.

(a) STAFF.—The Commission may appoint and determine the compensation of such staff as may be necessary to carry out the duties of the Commission. Such appointments and compensation may be made without regard to the provisions of title 5, United States Code, that govern appointments in the competitive services, and the provisions of chapter 51 and subchapter III of chapter 53 of such title that relate to classifications and the General Schedule pay rates.

(b) CONSULTANTS.—The Commission may procure such temporary and intermittent services of consultants under section 3109(b) of title 5, United States Code, as the Commission determines to be necessary to carry out the duties of the Commission.

SEC. 305. POWERS.

(a) HEARINGS AND OTHER ACTIVITIES.—For the purpose of carrying out its duties, the Commission may hold such hearings and undertake such other activities as the Commission determines to be necessary to carry out its duties.

(b) STUDIES BY GENERAL ACCOUNTING OFFICE.—Upon the request of the Commission, the Comptroller General shall conduct such studies or investigations as the Commission determines to be necessary to carry out its duties.

(c) COST ESTIMATES BY CONGRESSIONAL BUDGET OFFICE.—

(1) Upon the request of the Commission, the Director of the Congressional Budget Office shall provide to the Commission such cost estimates as the Commission determines to be necessary to carry out its duties.

(2) The Commission shall reimburse the Director of the Congressional Budget Office for expenses relating to the employment in the office of the Director of such additional staff as may be necessary for the Director to comply with requests by the Commission under paragraph (1).

(d) DETAIL OF FEDERAL EMPLOYEES.—Upon the request of the Commission, the head of any Federal agency is authorized to detail, without reimbursement, any of the personnel of such agency to the Commission to assist the Commission in carrying out its duties. Any such detail shall not interrupt or otherwise affect the civil service status or privileges of the Federal employee.

(e) TECHNICAL ASSISTANCE.—Upon the request of the Commission, the head of a Federal agency shall provide such technical assistance to the Commission as the Commission determines to be necessary to carry out its duties.

(f) USE OF MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as Federal agencies.

(g) OBTAINING INFORMATION.—The Commission may secure directly from any Federal agency information necessary to enable it to carry out its duties, if the information may be disclosed under section 552 of title 5, United States Code. Upon request of the Chairman of the Commission, the head of such agency shall furnish such information to the Commission.

(h) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Commission, the Administrator of General Services shall provide to

the Commission on a reimbursable basis such administrative support services as the Commission may request.

(i) ACCEPTANCE OF DONATIONS.—The Commission may accept, use, and dispose of gifts or donations of services or property.

SEC. 306. REPORT.

(a) REPORT ON COMPREHENSIVE LONG-TERM CARE SERVICES FOR THE ELDERLY AND DISABLED.—The Commission shall submit to Congress a report, not later than 6 months after the date of the enactment of this Act, containing its findings and recommendations regarding comprehensive long-term care services for the elderly and disabled. The report shall include detailed recommendations for appropriate legislative initiatives respecting such services.

(b) REPORT ON COMPREHENSIVE HEALTH CARE SERVICES.—The Commission shall submit to Congress a report, not later than 1 year after the date of the enactment of this Act, containing its findings and recommendations regarding comprehensive health care services for the elderly and disabled and comprehensive health care services for all individuals in the United States. The report shall include detailed recommendations for appropriate legislative initiatives respecting such services.

SEC. 307. TERMINATION.

The Commission shall terminate 30 days after the date of submission of the report required in section 306(b).

SEC. 308. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated $1,500,000 to carry out this title.

PURPOSE AND SUMMARY

The purpose of H.R. 2470 is to protect the elderly and disabled population from the financial disaster caused by catastrophic health care expenditures not currently reimbursed under the Medicare and Medicaid programs. The bill would substantially reduce the required cost sharing under Medicare, would require the States to extend eligibility under Medicaid, and would enhance the benefits covered under both programs.

The bill has three titles. Title one restructures and simplifies the coverage rules for Part A of Medicare and establishes an income-related supplemental premium which will raise revenues equal to or greater than the cost of the bill's Medicare improvements. Medicare enrollees needing inpatient hospital care would pay only one hospital deductible per year. The bill would eliminate the "spell of illness" concept, as well as the current-day limitations and coinsurance requirements on inpatient hospital stays. The skilled nursing home benefit would also be revamped. The requirement of a three day prior hospital stay would be eliminated, the days covered would be extended from 100 to 150 days, and the coinsurance would be changed to require enrollees to pay 20% of the national average per diem cost for each of the first seven days. Coverage of hospice care would be extended and the blood deductible requirements reduced. In addition, the current rule that home health benefits should be paid under Part A for patients enrolled in both Part A

and Part B would be reversed, so that payment in those circumstances would be made under Part B.

The income-related supplemental premium would be collected by the Internal Revenue Service as part of the income tax system. Individuals entitled to Part A of Medicare would pay an amount based on adjusted gross income and determined according to a table included in their tax forms.

Title II contains improvements in Part B of Medicare. It would establish an upper limit on the amount of cost sharing a Part B enrollee would be required to pay each year. After an enrollee had met the limit, Medicare would pay 100% of the reasonable charge (or reasonable cost) for any subsequent Part B services. The limit would be $1043 in 1989, and would increase by the Social Security COLA in the following years.

Title II would also provide Medicare coverage for outpatient prescription drugs, subject to a $500 annual deductible, and would provide up to 120 hours per year of home health aide and personal care services for chronically dependent individuals, living with a primary caregiver, who cannot be left alone in their homes. Both of these new benefits would be financed with enrollee premiums. The existing home health benefit would be made available on a daily basis for up to 35 days, and the existing limitation on payments for outpatient mental health treatments would be increased from $250 per year to $1000 per year. Medicare coverage would be extended to influenza vaccines, without any deductible or coinsurance. All Part B enrollees would pay an additional premium of $1 per month in 1990 and $1.50 per month in 1991 and 1992 (plus the additional monthly premiums needed to finance the prescription drug, in-home care, and flu vaccine benefits added by the bill.) All enrollees would be sent an annual notice explaining the benefits and limitations of the Medicare program and would receive a directory of participating physicians for their area.

States would be required to pay the Medicare premiums, deductibles and coinsurance for all Medicare enrollees with incomes at or below the Federal poverty guideline and assets at or below twice the Supplemental Security Income guidelines. States would also have to allow the spouse, living at home, of a medicaid-eligible nursing home resident to retain at least $925 per month in income and at least $12,000 in assets. Finally, States would be required to delay Medicaid eligibility to individuals who transfer countable resources for less than fair market value within two years of application for Medicaid benefits.

Title II would also require conforming changes in the requirements for Medicare supplemental policies, would extend the existing Medicare demonstration projects for social health maintenance organizations, would require a study of comprehensive health care coverage by the General Accounting Office, and would require the Secretary of Health and Human Services to conduct research on long-term care and a study of adult day care.

Title III would establish 15 member Bipartisan Congressional Commission to report within 6 months on expanding long-term care services under Medicare and within 12 months on providing comprehensive health care for all Americans.

Background and Need for Legislation

When Medicare was enacted in 1965, it was patterned after private health insurance policies generally available at that time. Although there have been marginal changes and improvements in the program over the last 22 years, the basic structure and benefits of the program have remained intact. During those 22 years, however, there have been extraordinary changes in health care technology and the delivery of health care services. In addition, the costs of health care have been rising at an accelerating pace. As a result, the Medicare program has been covering a decreasing proportion of the health care needs and costs of its enrollees.

The Medicare progam provides reasonable protection for short term acute hospital stays and for other acute care. However, its protections are less adequate for those enrollees with chronic conditions or extended hospital stays, or in need of long-term care.

Today, Medicare pays only 45% of the health care expenditures incurred by the elderly. Yet, the elderly incur, on average, three times the health care costs incurred by the nonelderly. The elderly are paying as much of their income, on average, for health care now as they spent the year before Medicare was enacted. Many of the elderly cannot afford these expenses. According to Congressional Budget Office testimony at a hearing of the Subcommittee on Health and the Environment, held on March 26, 1986, over 12 percent of the elderly have incomes below poverty and over 20 percent have incomes below 125% of poverty.

Many Medicare enrollees seek additional protection against the costs of health care. About 9% are eligible for Medicaid, and have their Medicare premiums and cost-sharing paid by Medicaid. However, nearly a third of those enrollees with incomes below the Federal poverty guidelines are not eligible for Medicaid, because of restrictive eligibility criteria. Over two-thirds of Medicare enrollees purchase Medicare supplemental policies—or Medigap—at an average cost of over $500 per year. These policies cover most of the cost-sharing for Medicare covered services, but they do not typically cover additional benefits, and their administrative costs frequently exceed 40% of premiums, in contrast to the 2.5% of Medicare outlays that go for administration of the program. Roughly 20% of Medicare enrollees have no additional coverage, principally because they cannot afford Medigap and do not qualify for Medicaid.

The elderly population is projected to grow substantially over the next several years, particularly those over age 75 and age 85. Many of these elderly will suffer chronic conditions and will be vulnerable to the catastrophic costs of health care. They will be at risk not only for the cost-sharing on Medicare covered services, but also for the costs of services not covered by Medicare. Two notable gaps in the Medicare program, identified by elderly constituency groups as being priority concerns, are outpatient prescription drugs and long-term care.

All of these factors and concerns have led to a growing awareness among members of the Committee and the general public that the benefit limitations, gaps in coverage, cost-sharing requirements, and obscure coverage rules of the Medicare program are in need of re-examination and revision. Medicare enrollees are in dire

need of better protection against the financial devastation of catastrophic health care expenditures.

Explanation of Legislation

Title I—Provisions Relating to Part A of Medicare

Title I of H.R. 2470 is not within the jurisdiction of the Committee and was not amended. The following explanation of Title I, as reported by the Committee on Ways and Means on May 19, 1987, is included to provide a complete report.

Inpatient hospital services (section 101)

Under current law, beneficiaries are required to pay a first day deductible for inpatient hospital services furnished in each "spell of illness". (A "spell of illness" is a period of consecutive days that begins with the first day on which a patient is furnished inpatient hospital or extended care services and ends with a period of 60 consecutive days during which the beneficiary was not an inpatient of either a hospital or a skilled nursing facility. A beneficiary may be discharged from and readmitted to a hospital or skilled nursing facility several times during a "spell of illness" and still be in the same spell, if 60 days have not elapsed between discharge and readmission.) The inpatient hospital deductible is $520 in 1987.

A beneficiary is entitled to inpatient hospital services for up to 90 days in any one spell of illness. In addition to the 90 days of hospital care, each beneficiary has a lifetime reserve of 60 days of added coverage after the 90 days have been exhausted. After a beneficiary has received 90 days of care in a spell of illness and exhausted the 60 lifetime reserve days, Medicare does not provide for further hospital reimbursement and the beneficiary is responsible for all hospital charges.

Beneficiaries are also required to pay coinsurance when inpatient hospital services are received for more than 60 days during a spell of illness. The beneficiary is responsible for a coinsurance amount for each day after the 60th and through the 90th day, equal to one-fourth of the inpatient hospital deductible ($130 a day in 1987). There is also a coinsurance amount for each day that is chargeable against the individual's 60 lifetime reserve days. The coinsurance for these days by law is equal to one-half of the inpatient hospital deductible ($260 a day in 1987).

Under current law, the amount of the hospital deductible is revised each January and is equal to the inpatient hospital deductible for the preceeding calendar year, updated by the same percentage that applies to prospective payment (PPS) rates and adjusted to reflect changes in real case mix.

Individuals age 65 or over who are not entitled to Hospital Insurance (Part A) benefits may voluntarily enroll in the Hospital Insurance program if they pay a monthly premium. The premium currently does not reflect the actuarial value of the Hospital Insurance benefit. Instead, the Secretary is required to calculate the premium each year under a formula that is equal to $33 multiplied by the ratio of the inpatient hospital deductible for the subsequent calendar year to the deductible promulgated for 1973.

This bill would make several changes in these provisions. A beneficiary would be required to pay only one hospital deductible in a calendar year no matter how many times the beneficiary was admitted to a hospital during the calendar year. The "spell of illness' methodology would be eliminated for determining the number of hospital deductibles, ther number of days Medicare would cover, and the hospital coinsurance amounts. A new deductible would not be required if the hospitalization began in one calendar year and continued into the following year, but a deductible would be required if the beneficiary reentered the hospital later in the second year.

The Medicare limits on payment for 150 days of inpatient hospital care would be eliminated, so that Medicare would pay for an unlimited number of hospital days for covered services in a calendar year. (However, the current 190 day lifetime limit and 150 day rule on inpatient psychiatric hospital services would be retained.) The current requirement for the payment of hospital coinsurance amounts for inpatient days 61 through 90 and the 60 lifetime reserve days would also be eliminated.

The method of determining the inpatient hospital deductible beginning in 1988 would be changed so that it would equal the preceding year's deductible, increased by the cost-of-living adjustment of Social Security benefits. Not later than November 15 of each year, beginning in 1987, the Secretary would be required to promulgate the inpatient hospital deductible for the succeeding year.

The Secretary would be required to establish a monthly Part A premium equal to the actuarial value of the Part A benefit for those who voluntarily enroll in Part A. The actuarial value would equal one-twelfth of the estimated average annual per capita amount payable from the Hospital Insurance Trust Fund for services and related administrative costs incurred in the succeeding calendar year for individuals age 65 and over entitled to hospital benefits during that entire year. The Secretary would be required to determine and promulgate during September of each year and issue a public statement setting forth the actuarial assumptions and basis employed in determining the actuarial rate.

When adjustment payments under the Medicare hospital prospective payment system, the Secretary would be required to take into account the reductions in beneficiary payments to hospitals because of the elimination of the day limitation. The Secretary, when appropriate, would adjust the payment rates under the prospective payment system (PPS), the outlier cutoff points, the weighting factors, and the target amounts for paying non-PPS hospitals.

The changes relating to the deductible would be effective for inpatient hospital services furnished on or after January 1, 1988, and succeeding years. However, in the case of an individual for whom a "spell of illness" began before January 1, 1988, and had not yet ended as of such date, the deductible would not apply to services furnished during that spell of illness during 1988 or 1989.

The changes relating to the extension of benfits and coinsurance would be effective for inpatient hospital services furnished on or after January 1, 1988.

The changes relating to the Part A premium would apply to premiums for months beginning with January 1, 1988.

The Secretary, when appropriate, would adjust inpatient hospital payments to hospitals for services furnished on or after January 1, 1988.

Extended care services (section 102)

Under current law, a beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible for each day after the 20th and before the 101st day of extended care services furnished during a "spell of illness". This coinsurance amount is $65 a day in 1987. A beneficiary is entitled to post-hospital extended care services in a qualified skilled nursing facility for up to 100 days in any one spell of illness, but the services in a skilled nursing facility are covered under Medicare only after an individual has been transferred to the facility from a hospital in which the individual was a patient for not less than three consecutive calendar days.

Under the bill, a Medicare beneficiary would be required to pay coinsurance amounts for the first 7 days of covered services in a calendar year. The coinsurance amount for each day would equal 20 percent of the national average per diem Medicare reasonable cost for SNF services in the succeeding calendar year, as estimated by the Secretary each year. The Secretary would, in September of each year (beginning in 1987), promulgate the coinsurance amount which shall apply to post-hospital extended care services furnished in the succeeding year.

The Medicare program would cover up to 150 days of post-hospital extended care services furnished during a calendar year. The three day prior hospitalization requirement to receive extended care services in a skilled nursing facility would be eliminated.

The coinsurance and extension of days would be effective for services furnished on or after January 1, 1988. The elimination of the three day hospital requirement would become effective for skilled nursing facility stays beginning on or after January 1, 1989.

Hospice care (section 103)

Under current law, a beneficiary who is terminally ill is entitled to elect to receive hospice care for two periods of 90 days and one subsequent period of 30 days, for a total of 210 days of hospice care. In order to receive the hospice benefit, the beneficiary's attending physician and the medical director (or staff physician) of the hospice program must certify, not later than two days after hospice care in initiated, that the beneficiary is terminally ill (i.e. that the beneficiary has a medical prognosis that his life expectancy is six months or less). If the beneficiary elects to receive hospice care for a second or third period, the medical director must recertify at the beginning of that period that the beneficiary is terminally ill.

Under the bill, a Medicare beneficiary would be entitled to a subsequent extension of the hospice benefit after the 210 day limit, if he or she was recertified as terminally ill by the attending physician or medical director.

These changes would be effective for hospice care furnished on or after January 1, 1988.

Blood deductible (section 104)

Under current law, a beneficiary is required to pay a separate deductible equal to the cost of the first three pints of whole blood (or equivalent quantities of red blood cells) received by a beneficiary as part of the services furnished under the hospital insurance (Part A) program during each "spell of illness." There is also a separate deductible under Part B of Medicare equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of red blood cells) furnished to a beneficiary during a calendar year.

In keeping with the elimination of the "spell of illness" concept for hospital services, it is necessary to conform the blood deductible rules and eliminate the spell of illness concept for the blood deductible.

A Medicare beneficiary would be responsible for payment of a deductible equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells) furnished each calendar year, except that the deductible for such blood would be reduced appropriately, in accordance with regulations developed by the Secretary of Health and Human Services, to the extent that there had been a replacement of such blood. The Secretary is directed to utilize the same replacement requirements that are currently used for the Part B blood deductible replacement requirements.

A Medicare beneficiary would be required to pay only one blood deductible in a calendar year under Parts A or B.

These changes would be effective for blood or packed red blood cells furnished on or after January 1, 1988.

Home health benefits (section 105)

Under current law, home health care is a covered benefit under both Medicare Part A and Part B. Eligibility and reimbursement policies are identical under both parts. There is no coinsurance or deductible payment requirement for home health under either Part A or Part B, and there is no limit on the number of home health visits covered by Medicare.

Payment for home health care, however, is currently made from the Part A trust fund for all home health services except for those provided to individuals enrolled under Part B, but not entitled to receive benefits under Part A. Only about 1 percent of home health is reimbursed under Part B.

Under current law, the Part B premium is set at 25 percent of total Part B program costs. Beginning in 1989, the Part B premium will be set at the lower of (1) an amount sufficient to cover one-half of the costs of the program, or (2) the current premium amount increased by the percentage by which cash benefits were increased under the Social Security cost of living adjustment (COLA).

Under the bill, beginning with fiscal year 1989, home health care would no longer be a covered benefit under Medicare Part A, except for individuals eligible for benefits under Part A who have not enrolled under Part B. Those individuals would continue to be eligible for home health benefits under part A. Individuals enrolled

under Part B would only be entitled to receive home health benefits under Part B.

There would be no change in coverage or reimbursement policies for home health services. There also would be no change in the Part B premium as a result of this provision: the 1989 premium would be based on the 1988 premium increased by the Social Security COLA.

This provision would be effective for home health services furnished on and after January 1, 1989.

Supplemental premium (section 106)

Under current law, individuals who have attained age 65 and who are eligible for monthly social security or railroad retirement cash benefits are eligible, without additional application, for coverage under the Hospital Insurance (Part A) program of Medicare without any payment for the coverage. Eligibility for Part A coverage begins with the first day of the month in which an individual attains age 65. Entitlement ends with the earlier of the last day of the month of death or the last day of the month before the month in which the beneficiary no longer meets the requirements for entitlement to social security, railroad retirement, or survivor benefits.

Part A coverage also is available, without payment of the Part A premium, to individuals under age 65 who have been entitled for not less than 24 months to social security or railroad retirement benefits on the basis of disability. This entitlement for Part A coverage applies to qualified railroad retirement disability beneficiaries and the following categories of social security beneficiaries: disabled workers, disabled widows and widowers between the ages of 50 and 65, certain women age 50 or older entitled to mother's benefits, and individuals age 18 and over who receive social security benefits because they became disabled before reaching age 22. Entitlement to Part A begins with the first day of the 25th month of entitlement to social security or railroad retirement benefits on the basis of disability. Such entitlement to Part A continues until the end of the month following the month in which notice of the termination of disability status is mailed to the beneficiaries, or, if earlier, with the end of the month before the month in which the beneficiary attains age 65.

Further, Part A coverage is available, without payment of the Part A premium, to individuals, even though they have not reached age 65, who have end-stage renal disease (i.e., kidney impairment that appears irreversible and permanent and requires either a regular course of dialysis or kidney transplantation to maintain life). End-stage renal disease Medicare benefits are available only after an application for Medicare benefits is filed.

Under the bill, an individual (other than certain individuals described below) who is eligible in any year for Medicare Part A coverage by reason of eligibility for social security, railroad retirement, disability, or end-stage renal disease benefits, and who is not required to pay the Part A premium, would be required to pay a supplemental premium based on the individual's adjusted gross income (AGI) for that year. The premium would be paid and collected in the same manner as an income tax.

The amount of the premium would be determined according to a table setting forth specified annual premiums for adjusted gross income brackets over $6,000. The table for taxable year 1988 is set forth in the bill. The minimum premium in 1988 is $10 and the maximum is $580.

The annual premium determined under this table would be prorated based on the number of months an individual is a medicare-eligble individual during the taxable year. The same rule is to apply in the case of a short taxable year, except that in such case, the individual's gross income would be annualized (assuming that the individual would have received adjusted gross income at the same rate for a full 12 months.)

In the case of a joint return, the premium table would be applied separately to each spouse who is a Medicare-eligible individual. For this purpose, the AGI of each spouse would be deemed to be one-half of the couple's combined AGI under the joint return.

By December 15 of each year, beginning in 1988, the Secretary would prescribe an adjusted table applicable to taxable years beginning in the immediately succeeding calendar year. The Secretary would adjust the premium amounts by the Medicare inflation factor. The other dollar amounts would be adjusted by the cost-of-living adjustment applicable to such year for purposes of the income tax brackets. Adjustments of amounts in the table would be rounded to the nearest dollar.

The Medicare inflation factor for any calendar year would be the percentage (if any) by which the Medicare value for such year exceeds the Medicare value for 1988. The Medicare value for any year is essentially the sum of (1) 50 percent of the value of Part A coverage, and (2) 75 percent of the value of Part B coverage.

Generally, an individual would be a "Medicare-eligible individual," and therefore would be responsible for the supplemental premium, if such individual is entitled to (or, on application, with no payment, would be entitled to) Part A coverage. An individual, other than a nonresident alien, would be treated as a Medicare-eligible individual for the month in which he attained age 65 and any subsequent month, unless such individual established to the satisfaction of the Secretary that he was not a Medicare-eligible individual for such month.

An individual would not be a "Medicare-eligible individual" for any month for which he was (1) entitled to benefits solely because he paid a Part A premium; (2) a resident of a U.S. possession who paid the extra Part B premium applicable only to such residents (see section 209, below); or (3) a qualified nonresident, as defined in the bill. The exemption for Part A enrollees who pay the Part A premium is based on the fact that such enrollees would have already paid for the full cost of Part A coverage. The residents of United States possessions would be exempted because they would have paid an additional part B premium for the new would be catastrophic benefits. Qualified nonresidents are viewed as, in effect, not receiving coverage under Part A and thus should be exempt from the supplemental premium.

For purposes of the rules regarding payment (including estimated payment) and collection of taxes, the supplemental premium would be considered an income tax.

It would not, however, be considered an income tax for purposes of determining either the amount of any credits allowable against income tax or the alternative minimum tax. Section 15 of the Internal Revenue Code, relating to changes in tax rates, would not apply to the supplemental premiums. The supplemental premium would not be treated as a medical expense for purposes of section 213, which allows a deduction for medical expenses in excess of 7.5 percent of AGI.

The supplemental premium provision of the bill would be effective for taxable years beginning after December 31, 1987.

TITLE II—PROVISIONS RELATING TO PART B OF THE MEDICARE PROGRAM AND TO THE MEDICAID PROGRAM

The following provisions were reported by the Committee as an amendment in the nature of a substitute for Title II, as reported by the Committee on Ways and Means.

Limitation on Medicare out-of-pocket expenses under part B (section 201)

The Supplementary Medical Insurance Program (Part B) covers physician services, hospital outpatient services, and a variety of other outpatient services, including clinical diagnostic laboratory tests, durable medical equipment, prosthetic devices, X-rays, renal dialysis, and home health services. Most of these are reimbursed on the basis of Medicare determined "reasonable charges", although some services are reimbursed on the basis of reasonable costs or according to fee schedules.

Before Medicare will start making payments, persons enrolled in Part B must pay a deductible of $75 per year, as well as an additional blood deductible for the first three pints of whole blood used in an outpatient setting during a year. In addition, for most Part B covered services, enrollees must pay coinsurance of 20% of the reasonable charge. Enrollees may also be responsible for additional out-of-pocket expenditures, if the physician or supplier of these services does not agree to take assignment of the enrollee's claim and charges the enrollee more than the Medicare program determines to be reasonable.

These expenses for cost-sharing and excess charges have grown rapidly, as the costs of health care have increased. Nearly nine percent of Part B enrollees, constituting approximately 2.8 million persons, will exceed $1000 in cost-sharing for Medicare-covered services. In addition, enrollees will be liable, on average, for nearly 30 percent more than the Medicare reasonable charge on those physician bills for which the physician does not take assignment. Medigap policies and the Medicaid program will assist many enrollees in meeting their Medicare cost-sharing obligations. However, approximately 20 percent of enrollees do not have such protection and those that do receive little or no assistance with the excess charges on non-assigned bills.

The bill would provide Part B enrollees with protection against catastrophic expenditures for cost-sharing on Medicare-covered services, by establishing a limit on such expenditures and having the program pay 100% of the reasonable charge (or reasonable

cost) for any covered services furnished during the calendar year after the limit had been met.

Expenses that would count towards the catastrophic limit would be the $75 annual Part B deductible, the Part B blood deductible, the 20% coinsurance, a maximum of $250 in cost-sharing for outpatient mental health treatments, and the reasonable expenses incurred by an enrollee for an annual colorectal examination for cancer or a triennial mammogram for detection of breast cancer. Medicare would not reimburse enrollees for the expenses of these two cancer screenings, but the expenses incurred by an enrollee would count towards the limit. The Secretary would be responsible for determining what costs were reasonable, and these would be the maximum amounts that could be counted towards the limit.

The catastrophic limit would be set at $1043 in 1989. In each succeeding year, the limit would be increased by the Social Security COLA. (The figure of $1043 for 1989 is equal to $1000 plus the projected increase in the Social Security COLA for 1989.) The Secretary would be required to publish the limit for each year by November 15 of the preceding year.

The Secretary would also be required to adjust the payments made to prepaid health care organizations, to take account of the catastrophic protections and other benefits established under this bill, which such organizations would be required to assume. The Committee expects the Secretary to make similar adjustments in the benefits covered by, and payments made to, organizations that are providing services under a prepaid capitation arrangement pursuant to a demonstration project or Medicare waiver, as appropriate to the terms and conditions of the project or waiver.

The bill would not provide an enrollee any direct financial protection against the excess charges, above those determined by Medicare to be reasonable, imposed by a physician or supplier who did not take assignment. Medicare would not pay such charges, nor would the physician of supplier be required to accept assignment. However, the bill would provide enrollees who had met the catastrophic limit with some assistance. Once an enrollee had met the catastrophic limit, if a claim were submitted on a non-assigned basis for subsequent physician services during the calendar year, the Medicare carrier would be required to notify the physician that the enrollee had already incurred sufficient out-of-pocket expenses to meet the limit. The notice to the physician would encourage the physician not to seek collection from the enrollee for amounts in excess of the Medicare reasonable charge and to accept assignment on any subsequent services during the year.

This is not expected to be an onerous task for the Medicare carriers. The carrier would already be generating a notice to the enrollee explaining its resolution of the claim, so this requirement essentially entails generating a duplicate notice to the physician, based on information that the carrier already has on hand.

The physician community has indicated on numerous occasions that physicians customarily take the patient's financial circumstances into account in deciding how much to charge and whether to take assignment. The notice called for under this provision would give the physician information about the patient that he or she might not otherwise have, bearing on the physician's decision.

It is the Committee's expectation that the physician organizations will support the implementation of this provision and will encourage their members to comply.

Coverage of catastrophic expenses for prescription drugs and insulin (section 202)

Outpatient prescription drugs that can be self-administered by the patient are not currently covered by Medicare, with the exception of immunosuppressive drugs needed by an organ transplant recipient. This gap in Medicare coverage imposes a substantial burden on enrollees. The elderly use 30 percent of all prescription drugs in this country, and use them at roughly three times the rate of the non-elderly. Many have chronic conditions that require them to take expensive medications on a regular, sustained basis in order to remain alive or to maintain their level of functioning. Nearly 5.5 million Medicare enrollees—almost 17%—incur more than $500 per year in prescription drug costs. Moreover, those who incur more than $500 in a year will average nearly $1,000 per year in drug costs. Less than half of the elderly have some form of insurance or receive some form of financial assistance with respect to the costs of these drugs, and such protection usually provides less than full coverage. National organizations representing the elderly have identified protection for these costs, along with better access to long-term care, as the highest priorities for improvements in the current Federal health care financing programs.

The Committee bill would provide catastrophic coverage for self-administered outpatient prescription drugs as a Medicare Part B benefit. The drugs that would be covered would include all those that require a prescription in order to be dispensed and are approved by the Food and Drug Administration as safe and effective. The bill would also include coverage for insulin and approved biologicals. (An existing provision of the Medicare statute would preclude payment for drugs for which the FDA has issued a notice of opportunity of hearing to withdraw the drug because it is less than effective. See section 1862(c) of the Social Security Act.) The bill would not change any current provisions under which Medicare already covers drugs, including payment for patients of skilled nursing homes, drugs provided "incident-to" a physician service, and immunosuppressive drugs.

Medicare payments would be subject to a deductible of $500 per year in 1989. In subsequent years, the deductible would be increased each year by the same percentage as the increase in the medical services component of the Consumer Price Index. This deductible would be separate and independent of the $75 Part B annual deductible and expenses incurred by the enrollee for drugs would not count toward the catastrophic limit of $1043 established in section 201 of the bill.

The enrollee would not have to show that he or she had paid these expenses out-of-pocket. If, for example, the enrollee had other insurance or was eligible for Medicaid, the expenses might be paid in whole or in part by those payers, but would still be counted toward the Medicare deductible. Once the deductible was met, there would be no further cost-sharing by the enrollee. Medicare would pay 100% of the allowed charge.

The Medicare allowed charge would be the lower of: (1) the actual charge of the dispensing pharmacist or agency, of (2) an amount established under a schedule of upper limits established by the Secretary. The limits would be established twice a year, for each drug product, and would consist of two components—one to cover the costs to the pharmacist of the drug being dispensed and the other to cover the overhead and administrative costs of the pharmacist, particularly the administrative responsibilities assumed by "participating pharmacists", as discussed below. Medicare would not pay a "dispensing fee" in addition to the allowed charge.

In calculating the limit, the Secretary would use the average wholesale price of the drug in question. Such average wholesale prices are readily available, on a national basis, from several services which compile and publish them on a monthly or quarterly basis. In the case of a brand name drug—sometimes referred to as the innovative drug or the drug which received the initial new drug application—the limit would be the average wholesale price of that drug product as of a date three months prior to the promulgation of the limit, plus an administrative allowance of $4.50. The Secretary would be instructed to calculate prices on the basis of units typically dispensed (per capsule, per tablet, or other dispensing unit) using reasonable quantities or package sizes customarily offered for sale by manufacturers and wholesalers.

These limits would normally be calculated on a nation-wide basis, but the Secretary would have authority to do so on a regional basis if he found significant variation by region in the average wholesale price or in the availability of drugs.

Limits would be set in a different manner for generic drugs. In those instances in which the FDA has approved one or more generic drugs as therapeutically equivalent to the brand name drug which received the initial new drug application, and listed the drug in its 'Orange Book" (formally entitled "Approved Drug Products with Therapeutic Equivalence Evaluations"), the Secretary would establish the limit based on the average wholesale price for the initial brand name of that drug. The Secretary would calculate 50% of the average wholesale price for the brand name, as of January 1, 1987, and would increase that amount for each six-month payment period by the percentage increase in the Consumer Price Index. The administrative allowance of $4.50 would be added to arrive at the upper payment limit.

The limit thus established for generic drugs would be the Medicare allowed charge, whenever an FDA approved generic was available, unless the prescribing physician or practitioner had specifically required that the brand name drug be dispensed. In order for Medicare to pay the higher amount for the brand name drug, the physician would have to indicate in his or her own handwriting that the brand name drug was medically necessary. The Secretary would be required to establish a particular phrase that would be used nationally, such as "Brand Medically Necessary." However, if a State currently had the same requirement for a physician's statement under its Medicaid program or under a generic substitution statute, but used a different phrase to achieve the same result, the Secretary could permit that phrase to be used in that state for pur-

poses of Medicare. However, it would have to be a written phrase, of three or more words, that reflected the physician's medical judgement that the patient's care required the brand name drug. Initials, abbreviations, preprinted signatures, or checking of preprinted forms would not satisfy the requirement. This restriction on the maximum Medicare allowable charge would be followed whenever the FDA had approved a generic drug, even if the State had not recognized that generic drug under its generic substitution policies.

The Secretary would be required to review this payment methdology and the limits described, and to report to the Congress by April 1, 1989, with any recommendations for changes or improvements. In order to prevent abusive practices in the prescribing or dispensing of drugs, the Secretary would also be authorized to establish guidelines or limitations on the frequency with which prescriptions are filled or on the maximum quantities that may be dispensed, particularly with respect to quantities dispensed at the end of a calendar year.

In order to facilitate the implementation of this new benefits, and keep program complications and administrative costs to a minimum, the bill would establish an arrangement under which pharmacists would assume significant responsibilities for assisting Medicare enrollees and Medicare carriers. Pharmacists could voluntarily sign an agreement to become a "participating pharmacy." Under the terms of the agreement, a participating pharmacy would accept assignment on all bills for drugs for Medicare enrollees who have met the $500 deductible. A participating pharmacy would also agree not to refuse to serve any Medicare enrollee and not to charge Medicare enrollees more than the charge to the general public. For this purpose, the general public would not include Medicaid patients, or subscribers of an HMO or of a insurance plan that has established discounts or special payment rules.

Additional elements of the participation agreement would include keeping patient records for all drugs dispensed to an enrollee, assisting the enrollee in determining, based on the pharmacist's records and any other records or information presented by the enrollee, whether he or she has met the $500 deductible, and filing with the Medicare carrier, on the enrollee's behalf, whatever documentation is required to establish that the deductible was met. In this regard, it is the Committee's intent that the Secretary establish a simple format and require only that information which is essential to making proper determinations and payments under the program.

A participating pharmacy would also agree to offer counsel to Medicare patients on the appropriate usage of drugs being dispensed, including possible interactions among drugs, and to advise enrollees on the availability of generics. In addition, a participating pharmacy would agree to share its records for an enrollee, at the enrollee's request, with another participating pharmacy that might be assisting the enrollee.

To facilitate this arrangement, the Secretary would be required to provide participating pharmacies with a distinctive emblem that they can display to the public and to make electronic billing available to participating pharmacies. The Secretary would also have to

notify the enrollee, and the participating pharmacy that submitted documentation on his or her behalf, whether the deductible had been met. In addition, the Secretary would be required to provide participating pharmacies with information on the payment limits prior to the start of each six-month payment period and to audit the charges of participating pharmacists to make sure that they did not exceed charges to the general public.

Medicare enrollees would not be required to choose a participating pharmacy or to obtain prescription drugs exclusively from one pharmacy. An enrollee could submit claims on his or her own behalf and could obtain prescription drugs from any pharmacist, participating or not. However, in order not to undermine the participating pharmacy program, non-participating pharmacies would not be allowed to submit claims on assignment. The Committee expects the Secretary to establish a system that would allow pharmacies to query, electronically, whether an enrollee has met the deductible.

This new benefit would he financed entirely with monthly premiums paid by all enrollees in Part B of Medicare. During September of each year, the Secretary would be required to determine the estimated aggregate costs, for both covered drugs and administration of the benefits, and the monthly premiums necessary to meet those costs. this monthly premium would be added to the monthly premium for Part B otherwise determined under the statute. Although this new provision would not be effective until January 1, 1989, the Health Care Financing Administration, and the Medicare carriers, would incur administrative costs in 1988 in preparing for implementation the following year. These administrative costs would also be financed by monthly premiums.

The committee bill would set an upper limit on the monthly premiums that could be set by the Secretary for each of the first three years. The Committee is concerned about differences in the cost estimates prepared by the Congressional Budget Office and by the Department of Health and Human Services. The limits on monthly premiums set forth in the bill are based on the most recent cost estimates available to the committee at the time it reported the bill. It is the committee's intent, however, that the provision be fully financed by premiums. The bill, therefore, includes special provisions to make sure that this occurs, while also protecting enrollees from large increases in their monthly premiums due to increases in the cost of the benefit beyond those currently projected.

As indicated above, the Secretary would be required to estimate the total costs of the benefit and calculate the monthly premium necessary to meet those costs. Beginning with the calculation of the monthly premiums for 1991, the Secretary would have to include in the estimated costs of the benefit any surplus or shortfall in the premium revenues for the preceding years, and calculate a monthly premium sufficient to account for such surplus or shortfall.

The premium, however, would not be allowed to increase in any year by more than 20 percent over the amount of the premium in the prior year, beginning again with respect to premiums for 1991. If the Secretary's estimate of the premium needed to finance the benefit indicated an increase of more than 20 percent over the prior year, the Secretary would be required to increase the deducti-

ble by an amount sufficient to reduce the total costs of the program to a level that would be fully financed by a 20 percent increase in the premium. This calculation would be done each year, beginning in 1991. If the deductible were increased under this provision in one year, it would not necessarily remain at the higher level in subsequent years. the Secretary would initiate the estimate of the total costs of the program in subsequent years, using the deductible that would otherwise be in effect in the absence of the increase needed in the prior year. If the estimate again indicated that a premium increase of 20 percent was not adequate to meet the costs of the benefit, the deductible would then again be increased as necessary to contain costs within the available financing.

For poor Medicare beneficiaries—those with incomes of less than $458 per month—a $500 annual deductible on prescription drug coverage represents a major financial burden. Under current law, most States pay Medicare Part B premiums and other cost-sharing for their elderly and disabled Medicaid beneficiaries. Due to restrictive income and resource standards used by State Medicaid programs, however, there are significant numbers of elderly and disabled with incomes below the poverty line who are not eligible for Medicaid and have to pay all of the Medicare cost-sharing requirements out-of-pocket.

The Committee notes that enactment of the Medicare drug benefit in this bill would result in significant savings to State Medicaid programs, almost all of which now offer prescription drug benefits to low-income elderly and disabled beneficiaries. If an individual who is eligible for both Medicare and Medicaid satisfies the $500 deductible, the Medicare program would cover all drug costs that the State now covers through its Medicaid program. In the view of the Committee, it is appropriate to require the States, in effect, to reinvest these savings in supplementing Medicare drug coverage for all their low-income elderly and disabled, not just those who are currently eligible for Medicaid.

The Committee bill would require States, through their Medicaid programs, to cover both the Medicare Part B premium (including any increment attributable to the prescription drug benefit), as well as the $500 prescription drug deductible, for all elderly and disabled Medicare beneficiaries with incomes below 100 percent of the Federal poverty guidelines and countable resources of up to twice the level permitted by the Supplemental Security Income (SSI) program ($3600 in 1987). The purpose of this provision, which parallels the general Medicaid "buy-in" requirement found at section 208 of the Committee bill, is to assure effective protection against catastrophic drug costs for poor Medicare beneficiaries.

With respect to coverage of the deductible, the bill would give the States two options. A State could either offer the Medicare beneficiary the same prescription drug benefit that it offers to its categorically needy Medicaid eligibles until the deductible is satisfied and Medicare coverage begins. Or, it could simply reimburse the beneficiary directly for the charges incurred for prescription drugs up to $500. Whatever method the State selects must apply to all qualified Medicare beneficiaries. If the State elected to offer its Medicaid prescription drug benefit, the calculation of whether the Medicare deductible had been satisfied would have to be based on

the actual charges for the drugs used, not on the amounts that the State actually reimbursed for the drugs through its Medicaid program.

State expenditures for Medicare prescription drug premiums and deductibles would be subject to Federal Medicaid matching payments at the State's regular matching rate for services. This buy-in requirement would, on July 1, 1988, take effect whether or not implementing regulations have been issued. Thus, States would begin paying the monthly Part B premium increments beginning July 1988, and would begin assisting qualified beneficiaries to meet the deductible with respect to drugs dispensed on or after January 1, 1989.

The provision would be effective, with regard to Medicare payments for prescription drugs, on January 1, 1989.

In-home care for certain chronically dependent individuals (section 203)

Among the Nation's elderly population, 3.6 million people (13 percent) live in the community and are disabled in some essential activities of daily living, such as eating, toileting, and moving from place to place. Over two-thirds of these individuals require considerable help to remain at home and in the community. According to the Congressional Budget Office, approximately 500,000 of them are so chronically impaired that they are unable to perform at least three activities of daily living without assistance. The nature of their impairments means that they need help everyday and they cannot be left alone.

Today, 80 percent of the most chronically dependent elderly live in a community setting. They neither reside nor receive care in a nursing home. Seventy-five percent of these individuals are able to stay at home and in the community because they have a primary caregiver—usually a spouse or child—who provides virtually all of their care. Without this assistance, these severely impaired individuals would have to be placed in a nursing home—at a greater cost—where they could receive the constant care and supervision they require.

In order to maintain this level of assistance and, in turn, to allow those who are chronically dependent to remain at home, the Committee bill would supplement the current Medicare home health benefit with certain limited and less skilled services for this population. Such medically-related services would be provided through Medicare certified home health agencies and would be offered in addition to, and not as an alternative to, current home health benefits under Medicare. Moreover, the Committee would establish separate conditions for eligibility for these services and not mandate that individual meet the requirements now in place for Medicare home health benefits.

The Committee intends the in-home benefit to provide limited assistance to those with chronic impairments who cannot live alone in the community. To qualify for such in-home care, a Medicare beneficiary would have to be unable to carry out two or more of the activities of daily living specified in the legislation (eating, bathing, dressing, toileting, and transferring in and out of a bed or in and out of a chair) without the assistance of a primary caregiver

who is living with the beneficiary. Individuals requiring such assistance would include those with cognitive impairments, such as those affecting people with Alzheimer's disease.

To be eligible for this new benefit, Medicare enrollees would have to be receiving assistance with respect to these designated activities, although help (either skilled or non-skilled) may also be provided (by the caregiver or other individuals under private insurance or publicly-financed programs) to meet different, additional health care needs. Moreover, assistance with these designated activities would have to be given on a daily basis for at least a three month period prior to the time coverage could begin. In addition, assistance would have to be provided by a caregiver who (1) is actually living with the beneficiary in a place of residence which both individuals use as a home; and (2) does not receive monetary compensation for the services he or she furnishes. This requirement is intended to exclude coverage for individuals whose care is provided by a paid employee of the beneficiary or his or her family. A physician's certification that these conditions were met would be required before eligibility for in-home care could be established.

Once eligibility is established, a beneficiary could receive up to 120 hours of in-home services during the remainder of the calendar year following physician certification. Services to be offered include homemaker or home health aide, personal services, and nursing care provided by a licensed practical nurse. These services could be furnished only in the beneficiary's home and must be delivered under the supervision of a registered professional nurse by (or through contract agreements or other appropriate arrangements with) a Medicare certified home health agency. The Committee bill would place no restrictions on the number of hours that may be consumed for each type of service that would be offered as part of the in-home care benefit. Thus, beneficiaries would be able to receive any or all of the three types of in-home care services specified in the legislation, so long as the total number of hours of services paid by Medicare does not exceed 120 in a calendar year.

In determining whether the 120 hour per year limitation has been met, in-home care that is provided for less than 3 hours on any individual day would be counted as 3 hours of such services. Payment for such services, however, would be made only on the basis of the actual amount of time spent in the provision of care. Medicare would pay 80 percent of the reasonable cost for the services provided and beneficiaries would pay 20 percent coinsurance, in the same manner as other Part B services. Thus, a beneficiary who receives 2 hours of homemaker services during a day would be considered to have received 3 hours of such care that would be applied against the total limitation of 120 hours, but the home health agency that provided the services would be paid only for the 2 hours of care that was actually given. Medicare would cover 80 percent of the reasonable cost for the 2 hours of services; the beneficiary would make a 20 percent coinsurance contribution. The Committee believes these procedures will help maximize its cost-effectiveness.

The costs of the in-home care benefit would be financed entirely through an increase in the premium that is paid by all individuals enrolled in Part B of the Medicare program. The additional

amount of the premium to pay for in-home care could not, however, exceed 40 cents in 1989, the first year of the program, and 70 cents in 1990. In subsequent years, the additional amount of the premium could not exceed 20 percent of the additional premium for the previous year. If revenues greater than those resulting from a 20 percent increase in premiums are needed in these years to finance the benefit completely, the Secretary would be required to reduce the maximum number of hours (120) to which a chronically dependent beneficiary would be entitled to in-home care. Further increases beyond the 20 percent of the additional premium for the previous year would be prohibited.

In order to evaluate this in-home care benefit, the Committee bill would require that the Secretary study and report on the extent of use, the cost, and the effectiveness of such care provided to chronically dependent individuals. The report would be made to the Congress no later than January 1, 1991. The Committee notes that, among other issues, the report should address the level of assistance required by the individuals who elect to use this benefit, as well as provide documentation of the types of services that are received. In addition, the report should include an analysis of the extent to which beneficiaries who receive in-home care are able to avoid or postpone permanent residence in a nursing home or other institutional setting.

The Committee bill would also require that the Secretary undertake a second, additional study relating to in-home care for the elderly who are chronically dependent. This report, to be made to the Congress not later than 18 months after the date of the legislation's enactment, is to contain information and recommendations regarding the provision of out-of-home services to chronically dependent individuals as an alternative to the in-home care to which these individuals are otherwise entitled. Such services include adult day care services (and other community-based arrangements) or nursing facility services. The purpose of this study is to learn more about the availability, accessibility, and appropriateness of providing these types of services as part of the in-home benefit package designed for chronically dependent individuals under this legislation. Thus, the Committee would expect this study to include information obtained from interviews with those Medicare beneficiaries who are receiving services under the in-home care benefit that this legislation would create. These interviews should establish the extent to which the limitation of services to the in-home setting has restricted the utilization and effectiveness of this benefit.

The new in-home care benefit would become effective on January 1, 1989.

Extending home health services (section 204)

Under current law, one of the requirements that must be satisfied in order for Medicare to cover home health care is that the care be required on an "intermittent" basis. This means, as a general rule, that persons who need care on a daily basis are not eligible for these services. The current guidelines for coverage, however, do permit daily skilled nursing visits for up to two or three weeks, if determined by the Medicare fiscal intermediary to be

medically necessary and reasonable. For this purpose, daily is defined as five days per week.

Concerns and criticisms have been raised about the implementation of this rule. The rule has not been uniformly and consistently applied. Moreover, it results in inadequate assistance for Medicare patients, particularly those who are discharged from hospitals in such a condition that they are unable to care for themselves or are in need of rehabilitative care.

The bill would expand and clarify the rule on intermittent care. Nursing care and home health aid services would be considered "intermittent", and reimbursable under Medicare, if they were furnished less than 7 days per week. In addition, these services could be provided 7 days per week for up to 35 days. They could be provided 7 days a week beyond 35 days if a physician certified that exceptional circumstances so required.

This provision would be effective on January 1, 1989.

Increase in maximum payment allowed for outpatient mental health services (section 205)

Under current law, the maximum amount that Medicare will reimburse for outpatient mental health treatments is $250 per year. Medicare will recognize only 62.5 percent of the reasonable charges for such services, and will pay only 80% of the recognized amount, with a total limit of $250 per year. As a consequence, the effective rate of coinsurance for an enrollee is 50% for the first $500 per year of treatments.

These limitations have not changed since the inception of the program in 1965 and are clearly inadequate to meet the needs of Medicare enrollees. These limitations encourage institutionalization of patients who need care but cannot afford to pay out-of-pocket for it and encourage undesirable billing and coding practices in order to maximize the availability of care.

The bill would increase the maximum amount of Medicare payments for such services to $1,000 in 1989. In order to avoid the erosion of the benefit over time, this limit would be increased in subsequent years by the Medicare Economic Index. (The MEI is the increase factor computed each year as the maximum increase in Medicare prevailing charges for physician services.) The current requirement of 50% cost-sharing would remain in effect, and only $250 in out-of-pocket expenses would be counted towards the catastrophic limit established under section 201 of the bill.

In addition, the bill would clarify that medical management physician visits are not considered to be treatments for purposes of this limitation. Medical management visits are visits of shorter duration than therapy or treatment sessions, and their main purpose is to permit the attending physician or psychiatrist to assess the patient's status, assess the treatment plan and the patient's progress, and perform necessary laboratory tests. Such visits are essential to the proper care of patients, but are discouraged under the current interpretation being followed by Medicare carriers, since any charges for such visits will decrease the availability of treatment. The Secretary has authority, under current law, to develop guidelines for the appropriate use and frequency of such visits, should he be concerned about potential abuses. Should the

Secretary seek to do so, the Committee would expect him to consult first with the physician and patient community on the need for and appropriateness of such guidelines.

The bill would not make any further changes, and the Committee intends none, with respect to other elements of current law regarding who can furnish such care or how the limit is applied.

Coverage of influenza vaccine and its administration (section 206)

Elderly Americans are far more susceptible than others to costly complications that may arise from influenza. As reported by the Office of Technology Assessment (OTA) to the Health Subcommittee at its 1982 hearings on the cost-effectiveness of the flu vaccine (Serial No. 97-128), during the period 1971-1978, 127,000 deaths and an estimated 16 percent increase in excess hospitalizations resulted from influenza, 80 to 90 percent of which occurred among those over age 65. More recent data from the Centers for Disease Control indicate that serious illnesses and deaths associated with influenza still remain a major health problem for the elderly.

OTA data also demonstrate that the cost to Medicare of such serious illnesses and hospitalizations could be avoided with adequate preventive measures, including widespread use of influenza vaccine. Again, during the years 1971-1978, these data show that flu shots not only increased the days of healthy life for persons age 65 and older, but also decreased the national level of their medical costs by $6.6 million. Such improvements and savings are particularly noteworthy, given the fact that they occurred with only a 22 percent flu vaccination rate among the elderly. Wider use of the vaccine by older Americans would undoubtedly result in even greater savings. In fact, the Congressional Budget Office (CBO) estimates that increasing the percentage of elderly who take influenza vaccine from 22 percent to 27 percent would yield Medicare savings of $15 million in 1988 alone.

For the last several years, the Department of Health and Human Services has acknowledged the cost-effectiveness of the flu vaccine through its recommendations to the general public that those at risk—including people 65 and older—be vaccinated against the disease each year. Yet, despite these recommendations, most of America's older population goes through the annual flu season without any vaccine protection.

Among the reasons cited at the Subcommittee's hearing for the elderly's low vaccination rate is the lack of coverage for flu shots under the Medicare program. In general, Medicare does not pay for preventive care services such as influenza vaccines. Thus, under current law, Medicare is authorized to pay for the treatment of influenza, but not for the vaccination that helps prevent this disease. Without such payment, seniors continue to be unwilling to take this simple preventive measure that could protect them against a catastrophic illness or even death.

The Committee bill would, therefore, amend the Medicare statute to provide coverage for the administration of vaccine against influenza. Under this provision of the bill, Medicare would pay 100 percent of the reasonable charge of the vaccination, without regard to the standard Medicare Part B deductible and coinsurance requirements. Beneficiaries would, therefore, have no out-of-pocket

expenditures if the physician takes assignment and accepts the Medicare reasonable charge as payment in full. If the physician does not accept assignment, the beneficiary would be responsible for the physician's charge in excess of Medicare's allowable level.

The costs of the vaccination would be financed entirely through an increase in the premium that is paid by all individuals enrolled in Part B of the Medicare program. It is anticipated that the amount of this increase would not exceed 20 cents per month. If, however, additional premium increases are needed in order for Medicare to pay for the vaccinations, the Committee bill would give the Secretary the authority to put such increases into effect.

The provision would be effective with respect to services furnished, and premiums paid, on or after January 1, 1989.

Mailing of notice of Medicare benefits and participating physician directories (section 207)

Surveys show that many Medicare enrollees do not fully understand what benefits are covered by Medicare or the limitations and constraints on those benefits. The Department of Health and Human Services currently publishes and distributes pamphlets describing the program, but misunderstandings remain. Of particular concern is the widespread misunderstanding that Medicare will cover nursing home and long-term care. Such misunderstandings may lead to enrollees making ill-informed decisions about purchasing supplemental policies or failing to take appropriate measures to secure needed health care. Passage of this bill would increase the need for enrollees to understand clearly the provisions of the Medicare program.

The Department recognizes the problem caused by enrollees' misunderstanding about Medicare's coverage of long-term care, as well as the need for an effective program of public education. The Secretary's report on catastrophic health care included a recommendation that such a program be undertaken. Members of the Committee have raised this issue with the Department on several occasions and have urged the Department to begin a public education program promptly.

The bill would require the Secretary to distribute a notice annually to all persons enrolled in either Part A or Part B, providing a clear and simple explanation of the benefits covered and those not covered under Medicare. In addition, the notice would explain the limitations on long-term care benefits under Medicare and Medicaid. It is the Committee's expectation that this would include, at minimum, an explanation inserted with the Social Security checks mailed to enrollees. It is also the Committee's intent that this be done within 90 days of enactment of the bill.

As part of the participating physician program created in 1984, the Department prepares directories of participating physicians, by area and specialty. These directories are currently made available in local Social Security offices, through hospitals, and through aging or consumer groups. In addition, enrollees are informed by a notice in their Social Security check envelopes that they can obtain a copy free from their Medicare carrier.

In order to provide greater access to these directories, the bill would require the Secretary to mail a copy to each enrollee.

Both provisions would be effective in 1988.

Requiring Medicaid buy-in of premiums and cost-sharing for poor Medicare beneficiaries (section 208)

Under current law, Medicare beneficiaries are obligated to meet certain deductible and coinsurance requirements under both Part A and Part B, as well as premium requirements under Part B. The Committee bill would restructure many of these cost-sharing requirements to establish catastrophic protection against hospital and physician expenses. However, all Medicare beneficiaries, regardless of income, would still be required to meet significant cost-sharing requirements before catastrophic protections are triggered.

In the case of those Medicare beneficiaries who are also eligible for Medicaid, most States, through their Medicaid programs, currently pay the Part B premiums under a "buy-in" agreement with the Medicare program. This assures that, for these individuals, Medicare pays the initial amounts of any claims for physician and other services covered under Part B, leaving the State Medicaid program with a supplementary role of paying for services that it covers, but which Medicare does not. States also pay Medicare deductibles and coinsurance on behalf of their dual eligibles. Federal Medicaid matching funds are available for such outlays, at the regular rate for services, with respect to Medicaid beneficiaries who are receiving cash assistance.

States also have the option, under their Medicaid programs, of paying Medicare cost-sharing requirements on behalf of low-income elderly and disabled Medicare beneficiaries who are not eligible for full Medicaid benefits. Under this option, added by section 9403 of P.L. 99–509, States may pay the Medicare cost-sharing for elderly and disabled individuals with incomes at or below a threshold established by the State that is no higher than 100 percent of the Federal poverty level. These individuals must also meet the resource standards of the Supplemental Security Income (SSI) program, although States that cover the "medically needy" may, at their option, apply their less restrictive "medically needy" resource in determining eligibility for this Medicaid "buy-in" coverage. If a State elects this option, it must, under current law, extend Medicare coverage to "some or all" of the optional categorically needy pregnant women and infants who are not eligible for Medicaid but whose incomes are below 100 percent of the Federal poverty level. Federal Medicaid matching funds are available, at the regular rate for services, with respect to the State expense of paying the Medicare cost-sharing for this optional categorically needy group, as well as for the costs of providing Medicaid benefits to pregnant women and infants.

According to the Congressional Budget Office, in 1986, about 3.3 million of the noninstitutionalized elderly 65 and over had incomes below the Federal poverty level. While virtually all of these have Medicare coverage, only about 1.1 million are covered under Medicaid. These dual eligibles may have their Medicare premiums, deductibles, and coinsurance obligations satisfied by the Medicaid program. The remaining two-thirds of the poor elderly must meet the Medicare cost-sharing requirements without help from Medic-

aid. Either they purchase "Medi-gap" insurance policies to pay the deductibles and coinsurance, or they pay the cost-sharing requirements directly out of pocket.

State Medicaid coverage of the elderly varies considerably. The following table, based on information supplied by the Congressional Research Service, sets forth, by State, the current Medicaid income eligibility levels for elderly persons living independently as a percentage of the Federal poverty level as of January, 1987. In most cases, these levels represent the maximum SSI benefit payment (the $340 Federal benefit plus any State supplement). In the 33 States which also cover the "medically needy," elderly individuals with higher monthly incomes may qualify for Medicaid by incurring high medical expenses which, when applied against their income, reduces their income to below the State's medically needy income level. (In all but 3 of these 33 States, the medically needy income level is lower than the maximum SSI benefit payment). The Committee observes that in only four States—Alaska, California, Connecticut, and Massachusetts—do Medicaid income eligibility levels for the elderly equal or exceed 100 percent of the Federal poverty level.

MEDICAID ELIGIBILITY LEVELS FOR ELDERLY INDIVIDUALS, BY STATE (JANUARY 1987)

	Monthly income level	Percent poverty ($458)
Alabama	$340	74
Alaska	632	[1] 110
Arizona	340	74
Arkansas	340	74
California	560	122
Colorado	398	87
Connecticut [2]	486	106
Delaware	340	74
District of Columbia	355	77
Florida	340	74
Georgia	340	74
Hawaii [2]	345	[1] 66
Idaho	413	90
Iowa	340	74
Illinois [2]	375	82
Indiana [2]	340	74
Kansas	340	74
Kentucky	340	74
Louisiana	340	74
Maine	340	74
Maryland	340	74
Massachusetts	469	102
Michigan	369	81
Minnesota [2]	375	82
Mississippi	340	74
Missouri [2]	340	74
Montana	340	74
Nebraska [2]	398	87
Nevada	376	82
New Hampshire [2]	367	80
New Jersey	371	81
New Mexico	340	74
New York	412	90
North Carolina [2]	340	74
North Dakota [2]	340	74

MEDICAID ELIGIBILITY LEVELS FOR ELDERLY INDIVIDUALS, BY STATE (JANUARY 1987)—Continued

	Monthly income level	Percent poverty ($458)
Ohio [2]	288	63
Oklahoma [2]	404	88
Oregon	342	75
Pennsylvania	372	81
Rhode Island	396	86
South Carolina	340	74
South Dakota	340	74
Tennessee	340	74
Texas	340	74
Utah [2]	350	76
Vermont	397	87
Virginia [2]	340	74
Washington	368	80
West Virginia	340	74
Wisconsin	442	96
Wyoming	340	74

[1] Federal poverty guideline for Alaska is $572 month, for Hawaii, $526 per month.

[2] States that do not automatically extend Medicaid coverage to aged or disabled persons receiving SSI benefits. Generally, individuals receiving SSI benefits are eligible for Medicaid in these States if they meet the State asset levels, which are lower than those under SSI. However, individuals with incomes higher than the levels indicated may qualify by "spending down," i.e., incurring medical expenses which, when applied against their incomes, reduce their incomes below the eligiblity levels.

The Committee bill proposes a number of Medicare benefit improvements designed to protect elderly and disabled Medicare beneficiaries against catastrophic financial expense. For Medicare beneficiaries with monthly incomes below $458 per month, however, these limited cost-sharing obligations will not be sufficient. Many of them will meet financial catastrophe long before they meet the $541 hospital deductible, the $1043 Part B cost-sharing "cap," and the $500 prescription drug deductible needed to trigger catastrophic protection under the bill. While States could protect this population through the Medicaid "buy-in" option under current law, it is the Committee's understanding that, to date, only one State has chosen to implement this coverage.

As a result of the proposed expansion of Medicare benefits to provide catastrophic coverage against hospital and physician costs, States, under their Medicaid programs, would realize significant savings. Dually eligible individuals who require extensive hospitalization and physician care would impose considerably less expense on State Medicaid programs than they do under current law, because payments that States now make for Medicare coinsurance and for services not currently covered by Medicare would no longer be necessary. In addition, some individuals who qualify for Medicaid by "spending down" to pay hospital and physician-related expenses not currently covered by Medicare would be protected from impoverishment by the bill's catastrophic benefits, and therefore remain ineligible for Medicaid. According to CBO, the aggregate Federal Medicaid savings resulting from the Medicare hospital and physician catastrophic limits in this bill would total an estimated $2.1 billion over the next five years. The state savings, in the aggregate, would total about $1.7 billion.

In the view of the Committee, this Medicaid "windfall" should be redirected toward catastrophic protection for the elderly and dis-

abled poor. Accordingly, the Committee bill would essentially make mandatory the Medicaid "buy in" option in current law. Effective July 1, 1988, the States would be required to pay the Medicare premiums, deductibles, and coinsurance for all elderly and disabled individuals with incomes at or below 100 percent of the Federal poverty level and resources at or below twice the SSI standard, or $3600. States would not be required to provide these individuals the full range of Medicaid benefits that they offer to categorically or medically needy beneficiaries; instead, they would be required only to pay Medicare cost-sharing on their behalf.

Under the bill, the income standard for this mandatory coverage group would be 100 percent of the Federal poverty income guidelines issued annually by the Department of Health and Human Services. These guidelines are based on poverty thresholds used by the Bureau of the Census to prepare its statistical estimates of the number of persons and families in poverty. For 1987, the income standard for an individual is $5,500 per year ($458 per month) for all States except Alaska and Hawaii. 52 *Fed. Reg.* 5340 (Feb. 20, 1987). Individuals with incomes above 100 percent of the poverty guidelines would not be eligible for this "buy-in", regardless of the amount of their incurred medical expenses; unlike "medically needy" coverage, "buy-in" coverage cannot be established by "spending down."

With respect to determining income eligibility for this "buy-in" coverage, the Committee intends that the States not use SSI standards or methodologies. In the case of married individuals, the Committee intends that the States, in determining income eligibility, not apply the poverty income guidelines for a family of two. Instead, the Committee expects that the states will attribute to each spouse one-half of all of the income, earned and unearned, received by either spouse, to each spouse, and apply that amount against the income guideline for a single individual. Thus, each member of a couple with a total annual income of $10,000 would be eligible for this coverage (assuming resource eligibility), since half of $10,000 meets the current poverty guideline for a single individual, even though their total income as a couple exceeds the poverty guideline of $7,400 per year for a family of two. In calculating income, the Committee expects that the States will either (a) multiply by four the individual's income for the three months preceding the determination of eligibility or (b) use the individual's actual income for the 12 months preceding the determination of eligibility. The States may require an applicant to furnish information that is reasonably necessary to substantiate his or her income.

With respect to determining resource eligibility for this "buy-in" coverage, the Committee expects that the State will use SSI methodologies for determining which assests are countable and which are not, and for valuing those resources. However, the State must use twice the SSI standards for countable resources; in 1987, this will result in a countable resource limit of $3,600 for an individual and $5,400 for a couple. As the SSI resource standard increases over time, the Medicaid "buy-in" resource standard will increase. The Committee notes that in 1974, when the SSI program was initiated, the resource standard was $1,500 for an individual. Had the 1974 standard been adjusted to account fully for inflation, the

standard in 1987 would be $3,400, not $1,800 as under current law. The Committee has set the resource standard at twice the SSI level for Medicaid buy-in purposes to assure those elderly with modest amounts of what the SSI program would consider "excess" resources are not denied protection against catastrophic health care costs.

The bill would require States to pay Medicare cost-sharing, including coninsurance, on behalf of eligible individuals. It is the understanding of the Committee that, with respect to dual Medicaid-Medicare eligibles, some States pay the coinsurance even if the amount that Medicare pays for the service is higher than the State Medicaid payment rate, while others do not. Under the Committee bill, States would not be required to pay the Medicare coinsurance in the case of a bill where the amount reimbursed by Medicare—i.e., 80 percent of the reasonable charge—exceeds the amount Medicaid would pay for the same item or service. However, if a State chooses to pay some or all of the coinsurance in this circumstance, Federal matching funds would, as under current law, be available for this cost. For example, assume that a physician actually charges a "buy-in" patient $60 for performing a particular procedure; that Medicare recognizes $50 as the reasonable charge; and that the State Medicaid program only pays $35 for this procedure. Whether or not the physician takes assigment, Medicare will pay only 80 percent of $50, leaving a $10 coinsurance obligation for the beneficiary. However, since the State only recognizes $35 as the fee for the procedure in question, and since the Medicare program has already paid the physician $40, the State is not required to pay any of the $10 coinsurance. If the State chooses to pay some or all of the $10, however, its cost would qualify for Federal matching payments at the regular rate for services.

The Committee bill would clarify that State expenditures for all Medicare cost-sharing expenses—premiums, deductibles, and coinsurance, under Part A or Part B—are eligible for Federal matching payments at the State's regular rate for service costs. This would apply whether the individual whose cost-sharing is being paid is eligible for Medicaid due to receipt of cash assistance, is eligible for Medicaid as a "medically needy" individual, or is eligible under the "buy-in" mandate of this bill as a "qualified Medicare beneficiary."

By making mandatory the current law "buy-in" option, the Committee bill would effectively require all States to provide Medicaid coverage to some or all pregnant women and infants who are not receiving cash assistance under the Aid to Families with Dependent Children (AFDC) program but who have incomes at or below 100 percent of the Federal poverty guidelines. It is the understanding of the Committee that at least 15 States have already elected to cover this optionally categorically needy group, and that most of these States have selected the 100 percent income threshold. The Committee bill would not require that all of the States cover all pregnant women and infants up to 100 percent of the poverty level; however, it would require that States cover these individuals below an income threshold set by the State that is higher than the State's current AFDC payment standard. As under current law, States covering these optional categorically needy pregnant women and infants must keep their AFDC payment levels at or above the

levels in effect on April 17, 1986. The effective date for coverage of some or all of these pregnant women and infants would be the same as for the "buy-in" mandate itself, July 1, 1988.

Adjustment in Medicare part b premium (section 209)

Persons enrolled in Part B of Medicare pay an monthly premium for such coverage. These premiums are established in advance for each calendar year. At present, the premium is calculated by the Secretary to be an amount sufficient, in the aggregate, to finance 25% of the estimated expenditures under Part B. Beginning with premiums for January 1989, however, the monthly premium cannot increase, under current law, by more than the percentage increase in Social Security cash benefits under the cost-of-living adjustment (COLA). The monthly premium is $17.90 in 1987, and is estimated by CBO to be $22.00 in 1988, $22.90 in 1989, $23.90 in 1990, $24.90 in 1991, and $26.00 in 1992.

Most of the revenue needed to finance the bill would be derived from the supplemental premium established under section 106. Additional premiums established under sections 202, 203 and 206. These revenues would not be adequate, however, to fully finance the program in each of the years. The bill, therefore, would increase the monthly premium by $1 in 1990 and by 40 cents in 1991. Because these increases would be incorporated into the premium and would be subject to the COLA increase, the net effect is that the monthly premium would be increased by $1.50 in 1991 and 1992.

The bill would also contain a provision making it clear that the transfer of payments for home health services from Part A to Part B, effectuated by section 105, will not have nay subsequent effect of increasing the monthly premium. The bill would require the Secretary, in calculating future premiums, not to take into account any increases in Part B expenditure due to this transfer.

Certain Medicare enrollees would not be paying the supplemental premiums established under section 106 of the bill. These would include residents of the U.S. Commonwealths of Puerto Rico and the Northern Mariana Islands and the Territories of Guam, the Virgin Islands, and American Samoa. It would also include persons who are enrolled in Part B of Medicare but who are not entitled to, and are not enrolled in, Part A. The latter group would not be paying the supplemental premium because they are not entitled to Part A. The residents of the commonwealths and territories would not be paying the supplemental premium because they are not subject to the Federal Internal Revenue Code and would not necessarily be filing a Federal income tax return.

The bill would provide that these persons will contribute to the financing of the additional catastrophic benefits of the bill by paying an additional monthly premium. In each case, the additional premium would be one-twelfth of the estimated annual per capita value of these additional benefits. For residents of the commonwealths and territories, the value would incude both Part A and Part B benefits, and would be adjusted by the ratio of the per capita value of Medicare benefits for such residents to the per capita value of Medicare benefits for residents of the U.S. For persons enrolled in Part B, but not Part A, the additional premium

would be based on the additional value of Part B benefits under the bill.

These additional premiums would become effective for residents of the commonwealths and territories in January 1988. For persons enrolled in Part B, but not Part A, they would become effective in January 1989.

Changes in certification of Medicare supplemental health insurance policies (section 210)

Section 1882 of the Social Security Act establishes requirements that insurance companies must meet in order to have their supplemental health insurance policies certified as "Medigap" policies. Section 1882 also includes criminal penalties for violating the provisions of that section, including penalties for knowingly selling a supplemental policy that substantially duplicates the benefits covered under Medicare. Insurance companies are also subject to State rules and regulations.

Medigap policies cover most of the current Part A and Part B cost-sharing, and sometimes include additional benefits. Over two-thirds of Medicare enrollees currently purchase such policies, at average annual premiums in excess of $500. The changes that would be made under this bill would clearly warrant significant changes in Medigap policies and in the requirements of section 1882. It is also clear that policy-holders need to be informed of these changes and their effect on current policies, and that companies issuing Medigap policies will need a reasonable period of time to adjust their policies to these changes and any corresponding changes made by the States.

The bill contains several provisions designed to bring Medigap policies into conformity with the changes made in Medicare. The Secretary of Health and Human Services would have to report to the Congress within 150 days of enactment of the bill, with recommendations for changes in the section 1882 requirements for certification. Before making such recommendations, the Secretary would have to take into consideration the changes in Medicare made by the bill and any recommendations made to him by the National Association of Insurance Commissioners.

The bill would also require insurers with Medigap policies in effect on January 1, 1988, to send a notice to all policyholders, by January 31, 1988, explaining the improved Medicare benefits enacted by the bill, and the effect of these improvements on the benefits and premium costs of the Medigap policy. Failure to do so would mean that the policy was no longer deemed to meet the requirements of section 1882. In addition, insurers would be required to submit their advertising to the State insurance commissioner (or comparable state officer) for review as to whether it complies with state law.

The criminal sanction for knowingly selling a policy that substantially duplicates Medicare benefits would be suspended from January 1, 1988 through December 31, 1988, with respect to policies issued prior to the enactment of the bill, if such policies would not have substantially duplicated Medicare benefits but for the enactment of the bill.

Extension of social HMO demonstration project (section 211)

Section 2355 of the Deficit Reduction Act of 1984 required the Secretary of Health and Human Services to approve Medicare and Medicaid waivers needed to implement a demonstration project for social health maintenance organizations. These organizations are to provide an integrated package of health, long-term care, and social services on a prepaid, capitation basis for persons who voluntarily enroll with the organization.

There are currently four such demonstration projects, located in: Brooklyn, New York; Minneapolis, Minnesota; Portland, Oregon; and Long Beach, California. The project is currently scheduled to conclude in the Fall of 1988. However, the Committee believes that, if the project were to conclude at that time, it would not have been in effect for a sufficient period of time for valid conclusions to be drawn regarding the effectiveness of the program and the desirability of incorporating such a provision into the Medicare program.

The bill would direct the Secretary to extend the demonstration project, under the same terms and conditions as the current waiver, through September 30, 1992. An interim report on the project would be due to the Congress by December 1988, and a final report would be due by March 31, 1993.

Study of comprehensive medical coverage under the Medicare program (section 212).

The gaps and limitations in Medicare covered benefits have resulted in enrollees paying a higher and higher proportion of their incomes for health care services not covered by the program. Beneficiaries and consumer groups have indicated their desire that Medicare benefits be expanded. In order to assist the Congress in making better informed decisions on these issues, the General Accounting Office would be directed to assess the need for, and cost of, expanding Medicare benefits to include a range of additional benefits, including preventive care and screenings, vision care, dental services, hearing exams and services, comprehensive long-term care, and prescription drugs. The GAO would be directed to make separate determinations with respect to the costs of these services if they were to be furnished on a fee-for-service basis and under a capitation arrangement. The report to Congress would be due within six months after enactment.

Research on long-term care services for Medicare beneficiaries (section 213)

In order to assist the Congress in making policy decisions with respect to Federal support for long-term care services, the Secretary of Health and Human Services would be directed to conduct additional research on the delivery and financing of comprehensive long-term care for Medicare enrollees. The bill would authorize $5 million per year for each of five years, to be appropriated in equal parts from the Part A and Part B trust funds. Such funds and research are to be in addition to the level of research currently being conducted on such issues by all of the agencies and offices of the Department of Health and Human Services. The research would

encompass a range of issues with respect to access, quality, financing, and other aspects of long-term care.

Protection of income and resources of couple for maintenance of community spouse (section 214)

The leading cause of financial catastrophe among the elderly is the need for long-term care, especially the need for nursing home placement. The expense of nursing home care—which can range from $2,000 to $3,000 per month or more—has the potential for rapidly depleting the lifetime savings of all but the wealthiest. Even under the Committee's bill, Medicare's expanded skilled nursing facility benefits will not protect the elderly against the costs of long-term institutionalization. Private insurance coverage for nursing home costs is not generally available. For most of the elderly, the Medicaid program is the only third party source of payment for nursing home care.

Medicaid, a means-tested entitlement program, requires that the elderly or disabled nursing home resident be poor in order to qualify for coverage. It also limits the income that an institutionalized spouse may make available for the spouse remaining in the community. If the institutionalized spouse receives the pension and other income in his name, this limit may have the effect of impoverishing the spouse in the community. The purpose of the Committee bill is to end this pauperization by assuring that the community spouse has a sufficient—but not excessive—amount of income and resources available to her while her spouse is in a nursing home at Medicaid expense. This will be of particular benefit to older women, who, in the current generation at risk of nursing home care, have often worked at home all their lives raising families and have limited income other than their husbands' pension checks.

Current law.—To determine how much is available for the community spouse to live on when her elderly spouse in the nursing home applies for Medicaid, it is necessary first to determine whether the institutionalized spouse is eligible for Medicaid based on income and resources. If eligibility is established, it is then necessary to determine how much of the institutionalized spouse's monthly income is to be applied to the cost of nursing home care, and how much is to be available to the community spouse.

Eligibility standards.—In general, in order to qualify for Medicaid, an individual must be categorically related—that is, be aged, blind, disabled, or a member of a family with dependent children—and must meet certain income and resources standards.

In most States, elderly or disabled people receiving cash assistance under the Supplemental Security Income (SSI) program are automatically eligible for Medicaid. Aged or disabled individuals may receive SSI benefits if their countable income and countable resources do not exceed specified standards. The basic SSI income standard for an individual in 1987 is $340 per month, but many States have elected to supplement this benefit with their own funds. The basic SSI resource standard for an individual in 1987 is $1,800. In determining countable resources, a number of items are excluded, including the individual's home (of any value), household goods and personal effects worth less than $2,000, an automobile

with a market value of $4,500 or less, and up to $1,500 in life insurance or burial funds.

Not all States automatically extend Medicaid coverage to SSI beneficiaries. In about 14 States, known as "209(b)" States, eligibility standards, particularly resource rules, more restrictive than those under SSI are applied to the elderly or disabled. In about 35 States, elderly individuals who are not poor enough to qualify for SSI, but who have large, recurring medical expenses, such as nursing home bills, qualify for Medicaid as "medically needy." Finally, about 30 States offer coverage, on an "optional categorically needy" basis, to nursing home residents whose incomes fall below a State-established special income level no higher than 300 percent of the basic SSI benefit level ($1,020 per month in 1987).

There are roughly 1.5 million Medicaid beneficiaries in nursing homes, whether skilled nursing facilities (SNFs) or intermediate care facilities (ICFs). Less than one-fourth of those are poor enough to qualify for SSI cash assistance. The remaining three-fourths are eligible either as "medically needy" or "optional categorically needy." Individuals who qualify for Medicaid in nursing homes on either of these bases must apply a certain portion of their income toward the cost of their nursing home care. It is these post-eligibility rules, in combination with the rules for attributing income and resources, that give rise to the problem of "spousal impoverishment."

Attribution of income.—When one spouse enters a nursing home (or other institution) and applies for Medicaid, the following rule determines the amount of that spouse's income for eligibility purposes. Shortly after institutionalization, each spouse is treated as a separate household. Income—generally Social Security checks, pensions, and interest or dividends from investments—is considered to belong to the spouse whose name is on the instrument conveying the funds (in the case of Social Security checks, the amount attributed to each spouse is the individual's share of the couple's benefit). Thus, in a case where a couple's pension check is made out to the husband, if the husband enters a nursing home, all of the income is considered his for purposes of determining eligibility. If the wife in this case enters the nursing home, however, none of the income is considered hers, and the husband is under no obligation under Federal law to contribute any of his income toward the cost of her care. (However, some States do impose spousal contribution requirements in these circumstances).

Attribution of resources.—The rule for attributing resources is basically the same as that for attributing income. Of course, the only resources that are attributed are countable resources, commonly liquid assets like savings accounts, mutual fund investments, certificates of deposit, etc. Generally, in the month following institutionalization, resources to which a spouse has unrestricted access, including joint savings accounts, are considered available to that spouse for eligibility purposes. Thus, if resources are held solely by the institutionalized spouse, they are attributed to him for eligibility purposes. If the resources are jointly held, they are also considered to belong entirely to the institutionalized spouse, on the theory that he or she has an unrestricted right to use them. If the assets are held solely by the community spouse, however, they

are considered, after the first month, to belong to her. There is no obligation under Federal law on the part of the community spouse to contribute any amounts of resources toward the costs of care of the institutionalized spouse. In the view of the Department, these attribution rules apply in all States, including those with community property laws: this Departmental interpretation is currently the subject of litigation.

Transfer of resources.—States have the option of denying Medicaid eligibility to individuals who have transferred countable resources for less than fair market value within two years of applying for Medicaid. In the SSI program, the uncompensated value of the resource is counted for 24 months from the month the resource was disposed of, regardless of the amount at issue. States can be less restrictive than SSI, but they can also be more restrictive as well. Where the value of the resorces for which no compensation was received exceeds $12,000, the State may deny eligibility for more than 24 months, beginning with the date of the transfer. States may waive this penalty in cases where undue hardship would result. In the case of transfers of an individual's home to someone other than a spouse or minor or disabled child, the period for which eligibility is denied, if any, must be based on the relationship between the value of the home for which no compensation was received and the average Medicaid expenditure for nursing home care. States cannot deny eligibility if the individual intended to dispose of the home at fair market value or if denial would cause undue hardship.

Post-eligibility application of income.—Once an institutionalized spouse has established eligibility for Medicaid by meeting the applicable income and resource standards, some of his monthly income is reserved for his use and that of his spouse, and the rest is applied to the cost of nursing home care. These post-eligibility income rules apply whether the spouse qualifies for Medicaid as a "medically needy" or "optional categorically needy" individual. From the gross monthly income of the institutionalized spouse are deducted the following amounts, in the following order. First, there is reserved for the institutionalized spouse a personal needs allowance for clothing and other expenses of at least $25. Second, there is set aside an allowance for the maintenance needs of the community spouse. This amount, combined with the community spouse's income, if any, allows the community spouse a certain amount of income, or maintenance needs level. Third, if the institutionalized spouse has a family at home, an amount is set aside for the maintenance of the family. Finally, an amount is allowed for expenses incurred for medical care that is not covered by the State's Medicaid plan or by Medicare or other third party. Any income remaining after these deductions is used to reduce the amount that the Medicaid program pays to the nursing home for the care of the institutionalized spouse.

Under current regulations, the maintenance needs level for the community spouse may not exceed the highest of the SSI, State supplementation, or "medically needy" income standard in the State. As the following table, based on a March 1987, survey conducted by the American Association of Retired Persons, indicates, these community spouse maintenance needs levels vary greatly

from State to State. The maintenance needs level is the total of the amount of the community spouse's income and the amount set aside from the income of the institutionalized spouse. Thus, in a State with a maintenance needs level of $340, if the community spouse receives a monthly Social Security check of $150, the contribution from the institutionalized spouse is $190, not $340.

Community spouse maintenance needs levels

State:	*Maintenance needs level*
Alabama	$340
Alaska	632
Arizona	(1)
Arkansas	188
California	534
Colorado	229
Connecticut	375–450
Delaware	164
District of Columbia	362
Florida	340
Georgia	340
Hawaii	300
Idaho	Up to 393
Illinois	267
Indiana	340
Iowa	340
Kansas	341
Kentucky	192
Louisiana	187
Maine	350
Maryland	325
Massachusetts	354
Michigan	358–370
Minnesota	397
Mississippi	340
Missouri	340
Montana	340
Nebraska	375
Nevada	173
New Hampshire	354
New Jersey	372
New Mexico	340
New York	417
North Carolina	233
North Dakota	345
Ohio	258
Oklahoma	0
Oregon	342
Pennsylvania	373
Rhode Island	475
South Carolina	340
South Dakota	257
Tennessee	150
Texas	340
Utah	289
Vermont	398
Virginia	217–325
Washington	368
West Virginia	200
Wisconsin	442
Wyoming	195

[1] Arizona operates, under demonstration authority, a Medicaid program that does not cover nursing home or other long-term care benefits.

Court-ordered support. —In some cases, courts have issued orders against institutionalized spouses requiring them to make monthly support payments in certain amounts to their spouses in the community. The policy of the Health Care Financing Administration (HCFA) is that, notwithstanding such an order, the income of the institutionalized spouse is to be considered available to him for purposes of determining the amount of his contribution toward the cost of nursing home care. The only part of his income which HCFA policy acknowledges as available to the community spouse is the specified maintenance needs allowance. This interpretation is the subject of litigation.

Committee bill. —The improvement of individuals whose spouses reside in nursing homes and receive Medicaid benefits is not justifiable. The current maintenance needs levels for community spouses, which are limited by current Federal regulation, are inadequate. In some cases, they have forced community spouses, in desperation, to sue their husbands for support. The financial duress that these low maintenance needs levels impose on the community spouse may, in certain cases, even force the premature institutionalization of that spouse.

The Committee bill would end spousal impoverishment. It revises the current Federal requirements relating to attribution of income, attribution of resources, transfer of resources, and post-eligibility application of income. These revisions are limited to the context of a couple with one spouse in an institution who applies for or receives Medicaid. The purpose of these revisions is to assure that the community spouse in these circumstances has income and resources sufficient to live with independence and dignity.

This bill establishes a uniform national spousal protection policy that applies in all States, whether they are "SSI," "209(b)," "medically needy," or "special income level" States, and whether or not they are community property jurisdictions. Should Arizona at some point offer nursing home coverage through its Medicaid demonstration, these rules would apply to it as well.

The bill allows an institutionalized spouse to elect to be governed by the rules that were in effect in his State as of March 1, 1987, regarding the treatment of income, the protection of income for the community spouse, the transfer of resources to the community spouse. The purpose of this election is to assure that the bill does not inadvertently make a community spouse worse off than under current law with respect to protected income of with respect to the minimum protected resource level of $12,000. This election could be used by the institutionalized spouse either to increase the amount of income or resources available to the community spouse or to reduce it, thereby allowing the community spouse to qualify for Medicaid or other public assistance benefits herself. However, the bill does not permit either the institutionalized spouse or the community spouse to opt out of the rules regarding the treatment of countable resources at the time of initial eligibility determination, which impose, in effect, a maximum protected countable resource limit of $48,000 on the community spouse.

Eligibility standards.—The bill does not alter income or resource standards for Medicaid eligibility of the institutionalized spouse. Thus, if the current resource standard is $1,800, it would remain

$1,800 under this bill. Similarly, the bill generally does not alter current law as to what income or resources are countable, and which are not, or how income or resources are valued. The principal exception to this relates to the exemption for household goods and personal effects for the limited purpose of attributing resources at the time of institutionalization. The spousal protection rules in this bill apply regardless of whether the institutionalized spouse has qualified for Medicaid by meeting the eligibility standards as a categorically needy, optional categorically needy, or medically needy individual.

Attribution of income.—During any month that a spouse enters a nursing home, hospital, or other institution, the following attribution rules apply for purposes of determining eligibility. Income paid solely in the name of one spouse or the other is considered to belong to that respective spouse. Thus, no income paid solely to the community spouse is considered available to the institutionalized spouse for eligibility purposes. If the income is paid in the names of both spouses, half is considered available to the community spouse, and half to the institutionalized spouse. If income is paid in the name of either spouse and another person or persons, the income is considered available to each individual names in equal proportional shares, unless the instrument controlling the income specifically otherwise provides. The same principles apply in the case of income from trust property. In the case of income from a trust where there is no instrument establishing ownership, half of the income is attributed to the institutionalized spouse and half to the community spouse. These attribution rules are subject to rebuttal by the institutionalized spouse upon a showing, by preponderance of the evidence, that ownership interests are otherwise.

Attribution of resources.—The following rules would apply in determining the amount of countable resources at the time of application for Medicaid benefits by the institutionalized spouse. First, a determination would be made of the total value of all the countable resources held by either the institutionalized spouse, the community spouse, or both, on the day the institutionalized spouse began the continuous period of institutionalization during which he applies for Medicaid benefits. Any countable resources belonging to either or both spouses would be included in this determination, including resources from inheritance or previous marriages. For this purpose only, the current limit of $2,000 on the equity value of the exemption for household goods and personal effects would be inapplicable. Thus, all household goods and personal effects, regardless of value, would not be counted among the resources attributed to the couple or either spouse at the time of institutionalization for purposes of determining eligibility.

One half of the value of all these resources, known as the spousal share, would be attributed to each spouse. If the spousal share of the community spouse were less than $12,000, the institutionalized spouse would be allowed to transfer a sufficient amount to the community spouse to enable her to hold countable resources in her own name of a total of $12,000. The institutionalized spouse would not be required to make this transfer; however, any resources not solely in the ownership of the community spouse would be attributed to the institutionalized spouse and, to the extent they exceed-

ed the applicable resource standard (generally $1,800), would render the institutionalized spouse ineligible for Medicaid.

If the spousal share of the community spouse were greater than $48,000, the institutionalized spouse would have attributed to him, for purposes of determining eligibility, both his own spousal share and the resources attributed to the community spouse in excess of $48,000. This $48,000 limit represents four times the $12,000 protected resource level. In 1989 and each year thereafter, these dollar amounts would be increased by the percentage increase in the consumer price index for all urban consumers for each year since September 1987.

The attribution of resources into spousal shares, and the subsequent imposition of limits on the community spouse's shares, would occur only once, at the time of initial application. After the month in which an institutionalized spouse has met the resource eligibility standard and is determined to be eligible for benefits, no resources of the community spouse, regardless of value, would be considered available to the institutionalized spouse. Thus, if while the care of the institutionalized spouse is being paid for by Medicaid, the community spouse's countable resources grow to exceed the $48,000 initial limit, the State would not be authorized to require the community spouse to apply any excess toward the cost of care of the institutionalized spouse.

The Committee observes that, in many cases, the institutionalized spouse may not apply for Medicaid benefits until months after his admission to a nursing home. Often these individuals and their spouses have "spent down" a significant amount of their life savings to pay the nursing home charges. Repeated division of the couple's total resources into equal spousal shares at each application or reapplication for benefits would result in the pauperization of the community spouse, as the couple's total resources would effectively be reduced to twice the resource eligibility standard, generally $3600, before the institutionalized spouse qualified for Medicaid. Precisely the opposite result is intended by the Committee. For this reason, the bill requires, in effect, that a "snapshot" of the couple's total resources be taken at the time of initial institutionalization, and that attribution of resources into spousal shares proceed on the basis of that "snapshot," regardless of the point at which the institutionalized spouse actually files application for benefits. The Committee expects that the States, in reconstructing the couple's resources at the time of institutionalization, will not apply unreasonable documentation requirements.

Post-eligibility application of income.—After an institutionalized spouse has met the resource and income criteria for eligibility, the income attributed to that spouse would be applied as follows each month. (The rules relating to attribution of income for purposes of determination of eligibility, described above, would also apply for purposes of post-eligibility treatment of income). From the institutionalized spouse's income, the following amounts would be deducted, in the following order. First, at least $25 would be reserved for that spouse's personal needs. Second, a community spouse monthly income allowance would be set aside. Third, a family allowance would be deducted for each minor or dependent child, dependent parent, or dependent sibling of either spouse living with the com-

munity spouse. Finally, there would be deducted amounts for incurred expenses for medical care for the institutionalized spouse not paid for by Medicaid, Medicare, or another liable third party.

The community spouse monthly income allowance is the amount needed to bring the community spouse's monthly income, including any income otherwise available to her, up to a minimum level. This minimum level is defined as the sum of (1) an amount equal to 150 percent of the Federal poverty guidelines for a family of two, or $925 per month in 1987; (2) an excess shelter allowance (the amount by which mortgage expenses or rent, plus utility costs, exceed 30 percent of the amount in (1); and (3) one-half of the amount by which the income of the institutionalized spouse exceeds the sum of amounts (1) and (2). The community spouse's minimum monthly maintenance needs allowance may not exceed $1500 per month. In 1989 and each year thereafter, this amount would be increased by the percentage increase in the consumer price index for all urban consumers for each year since September 1987. This $1500 limit applies only to the amount that may be deducted from the institutionalized spouse's income for the maintenance of the community spouse; it does not in any way constrain the amount of income that the community spouse may receive in her own name from sources other than the institutionalized spouse.

The $1500 limit on the minimum monthly maintenance needs allowance is not absolute. Under the bill, the institutionalized spouse is entitled to an opportunity to demonstrate, at a fair hearing, that the minimum monthly maintenance needs allowance is inadequate to support the community spouse without financial duress. If the spouse makes this showing, by a preponderance of the evidence, the State would be required to establish an adequate monthly maintenance needs allowance in that case.

Under the bill, States would be required, upon request by either spouse or upon a determination of eligibility, to notify the institutionalized spouse of the amount of the community spouse monthly income allowance, the family allowance, the way in which the community spouse resource allowance was computed, and the spouse's right to a fair hearing. The bill makes clear that an institutionalized spouse who believes that the minimum monthly maintenance needs allowance for the community spouse is inadequate, or who believes that the State has not accurately determined the amount of monthly income actually available to the community spouse from other sources, is entitled to a fair hearing on either of these issues, as well as any other State determinations that adversely affect the income or resources available to the community spouse.

Court ordered support.—The Committee recognizes that there will be some instances in which the rules set forth in the bill do not take adequate account of the special circumstances affecting a particular community spouse. The bill therefore provides that, if a court has entered an order against an institutionalized spouse for monthly income for the support of the community spouse, the community spouse monthly income allowance must be at least as great as the amount of the income ordered to be paid. Similarly, if a court has entered a support order against an institutionalized spouse requiring that spouse to transfer countable resources to the community spouse, the spouse may comply with the court's order

without running afoul of the transfer of assets prohibitions, even where the effect is to leave the community spouse with countable resources in excess of $48,000.

Transfer of resources.—The Committee is informed that a number of States have not made effective use of the authorities under current law to prevent affluent individuals from disposing of resources in order to qualify for Medicaid nursing home coverage. In the view of the Committee, Medicaid—an entitlement program for the poor—should not facilitate the transfer of accumulated wealth from nursing home patients to their non-dependent children. The Committee is also concerned by the arbitrary nature of current SSI policy relating to disposal of assets, under which the 2-year penalty for transfers is unrelated to the amount of the assets disposed of. Accordingly, the Committee bill replaces the current law option with a uniform national policy, mandatory on all the States, that is specific to Medicaid eligibility and that reasonably relates the value of the resources improperly transferred to the period of denial of eligibility.

Under the bill, States must determine whether each nursing home or hospital patient who applies for Medicaid has, within 2 years of application, disposed of any countable resources for less than fair market value. If such a transfer has occurred, the State must determine the value (as of the time of transfer) of the countable resources transferred for which the applicant received less than fair market value. The total uncompensated value of these countable resources must then be divided by the average cost, to a private patient at the time of application, of nursing home care in the State. This yields the number of months for which the individual is ineligible for Medicaid, beginning with the month in which the transfer took place. The Committee expects that, where practicable, the State should use the cost of nursing home care to private patients in the community in which the applicant is institutionalized.

To avoid inequitable results, the bill provides for a number of exceptions from the denial of eligibility for transfers of countable resources for less than fair market value.

First, the prohibition on transfer does not apply at all in the case of the transfer of an applicant's home to his or her spouse, child under 21, or blind or disabled adult child. The Committee recognizes that, so long as an individual lives in a home or intends to return to it, the home is not a countable resource. The purpose of this exception is to underscore that the transfer of an applicant's or beneficiary's home to the community spouse or to any minor or disabled children would be protected.

Second, the prohibition on transfers does not apply at all in the case of a transfer of countable resources to the community spouse of an institutionalized individual, or to another for the sole benefit of the community spouse. Since the Committee bill establishes rules for the attribution of resources of married couples at the time of institutionalization which reach both spouses, no purpose would be served by prohibiting transfers of countable resources from the institutionalized spouse to the community spouse.

Third, if an individual can demonstrate, to the satisfaction of the State, that he or she intended to dispose of the resources at fair

market value, or for other valuable consideration, denial of eligibility for Medicaid should not occur. The purpose of the Committee bill is to deter those who, through "gifting" or other disposal, knowingly seek to shelter assets from dissipation due to nursing home costs. The bill is not intended to penalize those who inadvertently, or through lack of sophistication, did not receive adequate compensation. Nor is the bill intended to deny eligibility to those who transfer resources to relatives or others by way of compensation for the informal care which these individuals have given to the applicant or beneficiary; the imposition of a penalty in such circumstances would have the unfortunate effect of discouraging family members and friends from caring for the frail elderly or disabled and helping them remain independent for as long as possible.

Finally, the Committee recognizes that there will be circumstances where, although an individual may have transferred assets in order to qualify for Medicaid benefits, the effect of denying Medicaid coverage for the specified period of time would be to seriously threaten the continuing care or well-being of the applicant or otherwise work an undue hardship. The Committee also recognizes that there will be circumstances where, with no expectation of needing nursing home care and no intent of qualifying for Medicaid, an individual may give away money or property, perhaps for a grandchild's education, and then later learn that, as a result of a rapid change in medical condition, such as a stroke, nursing home placement is suddenly required. The bill provides that where the State determines such circumstances exist, eligibility for Medicaid benefits must not be denied.

These prohibitions on transferring countable resources, and the exceptions to them, are mandatory on all the States. The Committee bill expressly provides that States are not authorized to impose more—or less—restrictive eligibility delays than those specified in the Committee bill. Thus, the States could not impose any penalties for transfers of resources on applicants or beneficiaries other than those in nursing homes or hospitals. Similarly, the current SSI policies relating to transfer of assets would no longer apply for purposes of determining Medicaid eligibility of applicants or beneficiaries in institutions or those outside.

Conforming changes.—Currently, a number of States that offer Medicaid coverage to the aged and disabled under the "medically needy" option use less restrictive income or resource methodologies in determining eligibility than apply to the aged and disabled under the SSI program. HCFA interprets current law to require that States use SSI income and resource methodologies under their medically needy programs for the elderly and disabled.

The current treatment of income and resources of institutionalized spouses—substantially revised by the Committee bill—is essentially the result of applying SSI principles in a Medicaid context. This is only one of many examples where principles that may be valid in the context of a cash assistance program are not appropriate in the context of a medical assistance program. The State Medicaid Directors Association has submitted a report to the Congress concluding that directly linking Medicaid and SSI income and resource methodologies results in impoverishment of the elderly and disabled, increased State and Federal costs, and burdensome ad-

ministrative practices. The Medicaid Directors offer a number of examples of SSI policies which are inappropriate when applied to Medicaid, such as the rule that resource eligibility is determined on the first day of the month. Following this SSI rule, if a nursing home patient has resources in excess of the allowable threshold ($1,800) on that day, he or she is ineligible for Medicaid throughout the rest of the month, even if the amount of excess resources is too small to enable the individual to pay for the entire month's nursing home costs.

In the view of the Committee, there is no justification for the rigid application of SSI eligibility rules to Medicaid medically needy programs. Prior to this HCFA interpretation, States had flexibility to establish income or resource methodologies less restrictive—i.e., more generous from the applicant's standpoint—than those under SSI. States should continue to have this flexibility. On the other hand, the Committee does not believe that the States should have the discretion to apply methodologies under their medically needy programs that are more restrictive—i.e., less generous from the applicant's standpoint—than those under SSI. The bill therefore provides that the State's methodology for determining eligibility for the medically needy aged and disabled shall be no more restrictive than that under the SSI program (or, in the case of families with children, under the corresponding Aid to Families with Dependent Children cash assistance program). To avoid any possible ambiguity, the bill provides that a methodology is considered to be "no more restrictive" if, using the methodology, individuals qualify for Medicaid even though they would not be eligible were the SSI methodology used, and individuals who would be eligible for Medicaid under the SSI methodology would not be ineligible under the State's medically needy methodology.

Effective dates.—The provisions relating to the treatment of income and resources for institutionalized spouses are effective for individuals residing in institutions on or after January 1, 1988. This includes spouses who were residing in nursing homes before that date, as well as spouses who are admitted on or after that date. The provisions relating to transfers of resources apply to all institutionalized individuals first applying for Medicaid on or after January 1, 1988, with respect to any transfers for less than fair market value occurring up to two years prior to the date of application. Both provisions are effective whether or not the Secretary of HHS has promulgated final implementing regulations. If the Secretary determines that a State requires State legislation, other than an appropriations bill, to implement these requirements, the provisions do not take effect until the first day of the first calendar quarter beginning after the close of the first regular State legislative session beginning after enactment. Finally, the provision allowing States to use less restrictive income and resource methodologies in their medically needy programs is October 1, 1982, the effective date of the current statutory language on which HCFA erroneously bases its current interpretation. No disallowances or other adverse actions may be taken against States based on the current statutory language relating to "same" methodologies.

Examples.—The following examples illustrate the operation of the Committee bill. Assume an elderly couple who together own a

home assessed at $110,000 and have a joint savings account, to which either spouse has unrestricted access, with a balance of $20,000. The husband's monthly income, from his Social Security benefit and his private pension, is $750. The wife, who worked at home all her life raising a family, has income of $150 from Social Security. The husband develops Alzheimer's disease and his wife, no longer able to care for him at home, must place him in a nursing home. The husband applies for Medicaid. The State covers "optional categorically needy" nursing home residents under a special income standard of $875 per month and a resource standard of $1,800. The State's maintenance needs allowance for community spouses is $340 per month.

Under current law, the husband is categorically related due to his age, and, as of the beginning of the first full calendar month after institutionalization, is eligible under the special income standard of $875. (Until the beginning of the first full calendar month, the wife's income is attributed to him, and he does not meet the special income standard). However, he must still meet the $1,800 resource standard. The entire amount in the couple's joint savings account is attributed to the husband, since he has unrestricted access to it, giving him excess resources of $18,200. Until he spends these excess resources, he will remain ineligible for Medicaid. If he gives the $18,200 to his wife, the State has the option of denying him Medicaid eligibility for more than 2 years from the date of transfer.

Assuming all the excess resources in the couple's joint account are applied to the cost of nursing home care, and assuming a private patient rate of $2,000 per month, it will take about 9 months for the husband to become resource-eligible for Medicaid. After eligibility has been established, the husband's income is applied as follows. First, an allowance of $25 is reserved for his personal needs. Then an allowance of $190 for the maintenance needs of his wife (the State standard of $340 minus the wife's own income of $150) is set aside. If the husband had no uncovered medical costs in the previous month, the remaining $535 of his income is applied to the cost of nursing home care. The remainder is paid by the State and Federal governments through Medicaid.

The wife in the community is left with the house, a monthly income of $340, and access to the $1,800 remaining in the couple's joint savings account. Before her husband entered the nursing home, the couple's total income ($900 per month) was about 146 percent of the Federal poverty level for a couple; after her husband's institutionalization, she has only $1,800 in liquid assets and her income places her at 75 percent of the Federal poverty level for a single individual.

In sharp contrast to current law, the Committee bill would not impoverish the wife in this case. At the time the husband enters the nursing home, only $750 in income would be attributed to him, and he would immediately be eligible under the State's special income standard. With respect to resources, half of the couple's total assets would be attributed to the wife and half to the husband. However, the bill allows the husband to transfer without penalty $12,000—the minimum community spouse resource allowance—to an account in his wife's name at any time. When the hus-

band has spent all but $1,800 of the remaining $8,000, he becomes resource-eligible for Medicaid. Assuming he applies all of these excess resources to the cost of his nursing home care at $2,000 per month, this will take about 4 months.

Once eligibility for Medicaid has been established, the husband's monthly income is applied as follows. First, $25 is set aside each month for a personal needs allowance. Second, $725 is reserved for the maintenance needs of the community spouse. The community spouse is allowed a minimum of $925, including her income; since the wife's income is only $150, she can receive at least $775 from the husband. However, since the husband's total income is less than $775, she receives only the total income less the $25 personal needs allowance, or $725. Nothing remains to reduce the cost of the husband's nursing home care to the Medicaid program.

Under the Committee bill, the wife is left with a monthly income of $875 (her Social Security check of $150 plus the maintenance needs allowance of $725), or about 190 percent of the Federal poverty level for a single individual. She also has $12,000 in savings in her name. The husband would qualify for Medicaid about 5 months earlier than under current law. The total Federal and State Medicaid payment to the nursing home would go up by $535 per month (the difference between the husband's $190 community spouse monthly income allowance under current law and the $725 allowance under the bill).

Another example will illustrate the effect of the bill's provision for an equal division of the couple's resources. Assume that the couple's joint savings account at the time of institutionalization contains not $20,000, but $50,000. Under the bill, the husband would be allowed, without penalty, to transfer $25,000 of this amount to an account in the wife's name. Of the remaining half, $23,000 would have to be spent before the husband would become resource-eligible for Medicaid. Under current law, all but $48,200 in the joint account has to be spent before the husband becomes eligible for Medicaid. (Although a couple with $50,000 in savings is likely to have household goods and personal effects valued at more than $2,000, the bill provides that all these items are not to be considered resources for purposes of determining the community spouse resource allowance).

The effect of the bill's ceiling of $48,000 on the community spouse resource allowance may be demonstrated by assuming that the couple has not $20,000, but $100,000 in joint savings accounts and jointly held stocks and mutual funds at the time of the husband's institutionalization. The bill allows the husband to transfer half of the jointly held resources, or $50,000, to the wife in her own name, subject to the limit of $48,000. Thus, the couple would have to spend $50,200 (the husband's $50,000 share, plus $2,000 excess resources from the wife's share, less the resource eligibility standard of $1,800) before the husband could qualify for Medicaid. Again, any household goods or personal effects would not be taken into account in determining the amount of the community spouse's resource allowance.

The effect of the bill on financial planning (or the lack thereof) can be illustrated with the following example. Assume that this couple has a total of $50,000 in savings, and because it has done no

financial planning, all of these resources are held by the husband in his own name when he is admitted to the nursing home. Under current law, the husband cannot qualify for Medicaid until all but $1,800 of this amount is spent. Under the bill, however, the husband may transfer $25,000 to the wife in her own name without penalty.

If one assumes that this couple, learning of the husband's disease, anticipated the need for institutionalization and transferred all of the $50,000 joint savings to the wife more than two years prior to application for Medicaid, the result under the bill is the same as in the previous example. Regardless of ownership, the resources are attributed in equal shares to each spouse. Until the wife's resources are reduced to $25,000, the husband is not resource-eligible for Medicaid. Under current law, the husband, with no resources attributable to him, would immediately qualify for Medicaid, and the wife would be under no Federal law obligation to contribute toward the cost of his care.

Finally, the concept of the resource "snapshot" at institutionalization is illustrated by the following example. Assume, as above, that couple has countable resources of $50,000, jointly held, at the time of the husband's admission to the nursing home. The husband does not apply for Medicaid upon admission; instead, the couple begins to spend it resources to pay for the cost of his care. After a year, the couple has spent $24,000 from its joint resources, and the husband applies for Medicaid. The State would then look back to the date of the husband's institutionalization for purposes of attributing resources. Since the wife's spousal share was $25,000 then, if the husband transfers his interet in $25,000 of the remaining resources to his wife, he will immediately be resource-eligible for Medicaid, since the remaining $1,000 would meet the $1,800 resource standard.

Study of adult day care services (section 215)

The Committee bill would require the Secretary of Health and Human Services to conduct a survey and report to the Congress on adult day care services that are currently being provided throughout the United States. Such a report is to include information on (1) the scope of adult day care services and the extent of their availability around the country; (2) the characteristics of the various entities (such as community-based programs, hospitals, and nursing facilities) that provide these services; (3) licensure, certification, and other quality standards that are applicable to those entities providing such services; (4) the cost and financing of adult day care services; and (5) the characteristics of individuals who use the services (including on the individuals' level of disability and on the availability of similar in-home care services).

The purpose of this review is to evaluate programs and projects that have already been established, so that Congress can properly consider the advisability of Medicare coverage for adult day care services. Thus, it is not the intention of the Committee that the Secretary undertake a demonstration project or in any other matter initiate or fund new adult day care programs. The Secretary is to report only on the current availability of services and on

the state of the art of the provision and monitoring of quality of adult day health services.

In addition to the material collected from the national survey, the Secretary's report to the Congress is to include various recommendations concerning the establishment of an adult day care benefit under the Medicare program. Among the issue to be addressed are the appropriate population to be served, the type of services to be provided, the qualifications for Medicare provider certification, and the method for reimbursement. More specifically, the Secretary is to make recommendations on who needs and uses adult day care services and what kind of organizational arrangements and staffing patterns would best meet these service requirements.

The Committee bill would require that the Secretary make his report to the Congress not later than 1 year after the enactment of this legislation.

TITLE III—UNITED STATES BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE

The bill would establish a 15-member Congressional Commission to make recommendations regarding Federal programs for comprehensive health care, and would authorize appropriations of $1.5 million for this purpose.

The Commission would be comprised of six members of the House appointed by the Speaker, six members of the Senate appointed by the President Pro Tempore, and three members appointed by the President. No more than eight members could be from the same political party. The Commission would select a chairman and vice chairman from among its members.

The Commission would examine shortcomings in the current delivery and financing of health care that limit or prevent access to comprehensive health care by the elderly and disabled and by all other Americans.

Within six months of enactment, the Commission would submit a report to the Congress, with findings and recommendations for appropriate legislative initiatives regarding comprehensive long-term care for the elderly and disabled. Within one year of enactment, the Commission would issue a comparable report on comprehensive health care services for the elderly and disabled and for all Americans.

For this purpose, comprehensive health care services would include hospital and physician services, screening examinations and other preventive care services, long-term care services, mental health services, prescription drugs, eyeglasses, hearing aids, and dentures. Comprehensive long-term care would include custodial and noncustodial services, furnished in facilities, the home, or community-based settings.

In making it recommendations, the Commission would consider the amount of funds necessary to finance needed services and possible sources of such funds, raised in a manner consistent with principles of social insurance. It would also consider the most effective and efficient manner of administering such services.

The Committee expects the Commission to examine carefully the effects of the current 29-month waiting period which the disabled

must satisfy before they become eligible for Medicare. For many of the disabled, this waiting period prevents their receiving health care during the period of time when they are most in need of it. Many of them do not have private health insurance during this crucial period and are unable to obtain rehabilitative or restorative care, while their condition worsens and many of them die. The Commission should examine, and make recommendations on, reducing or eliminating the waiting period, including an assessment of the costs and effects of the waiting period on the disabled.

The Commission would be empowered to appoint and compensate staff, procure consultants, hold hearings, request studies from the GAO and cost estimates from CBO, request technical assistance or the detail of employees from other Federal agencies, request support from the General Services Administration, obtain information from any Federal agency, and accept gifts or donations of services or property. The Commission would expire 30 days after the submission of its last report.

Hearings

The Committee's Subcommittee on Health and the Environment held four days of hearings on H.R. 1711, H.R. 1760, H.R. 1761, H.R. 1762, H.R. 2470, and H.R. 2485, on May 21, 27 and 28, and June 2, 1987. Testimony was received from 39 witnesses, representing beneficiary and consumer groups, health care providers, and a variety of other organizations.

Committee Consideration

On June 9, 1987, the Subcommittee on Health and the Environment met in open session and ordered reported the bill H.R. 2470, as amended, by a vote of 9 to 1, a quorum being present. On June 16 and 17, 1987, the Committee met in open session and ordered reported the bill H.R. 2470, with amendments, by a recorded vote of 30 to 12, a quorum being present.

Committee Oversight Findings

Pursuant to clause 2(l)(3)(A) of rule XI of the Rules of the House of Representatives, no oversight findings or recommendations have been made by the Committee.

Committee on Government Operations

Pursuant to clause 2(l)(3)(D) of rule XI of the Rules of the House of Representatives, no oversight findings have been submitted to the Committee by the Committee on Government Operations.

Committee Cost Estimate

In compliance with clause 7(a) of rule XIII of the Rules of the House of Representatives, the Committee believes that the bill will reduce the deficit by a total of $907 million over the fiscal years 1988, 1989, and 1990.

Congressional Budget Office Estimate

U.S. Congress,
Congressional Budget Office,
Washington, DC, June 29, 1987.

Hon. John D. Dingell,
Chairman, Committee on Energy and Commerce, House of Representatives, Washington, DC.

Dear Mr. Chairman: The Congressional Budget Office has prepared the attached cost estimate for H.R. 2470 Amended, the Medicare Catastrophic Protection Act of 1987, as ordered reported on June 17, 1987, by the Committee on Energy and Commerce.

If you wish further details on this estimate, we will be pleased to provide them.

With best wishes,
Sincerely,

Robert F. Hale
(For Edward M. Gramlich, Acting Director).

CONGRESSIONAL BUDGET OFFICE—COST ESTIMATE

1. Bill number: H.R. 2470 as amended by the Committee.
2. Bill title: The Medicare Catastrophic Protection Act of 1987.
3. Bill status: As amended and ordered reported by the Committee on Energy and Commerce on June 17, 1987.
4. Bill purpose: To amend title XVIII of the Social Security Act to provide protection against catastrophic medical expenses under the Medicare program, and for other purposes.
5. Estimated cost to the Federal Government:

[By fiscal years, in millions of dollars]

	1988	1989	1990	1991	1992
DIRECT SPENDING/OFFSETTING RECEIPTS					
Sec. 101 Provisions					
Eliminating the limit on covered hospital days:					
Budget authority	−10.0	−30	−60	−90	−130
Outlays	180.0	300	345	380	420
Eliminating enrollees' copayments for hospital coinsurance and reserve days:					
Budget authority	−15.0	−50	−95	−150	−210
Outlays	295.0	485	560	615	680
Limiting payment of the hospital deductible to the first stay each year:					
Budget authority	−20.0	−60	−110	−160	−220
Outlays	395.0	530	550	595	655
Indexing the first-stay hospital deductible amount to the COLA:					
Budget authority	(1)	−5	−15	−35	−65
Outlays	10.0	75	175	290	410
Changing the calculation of the pt. A premium:					
Budget authority	15.0	25	25	25	25
Outlays	15.0	25	25	25	25
Effect on trust fund from change in pt. A premium:					
Budget authority	−16.0	−27	−30	−30	−35
Outlays	0	0	0	0	0

[By fiscal years, in millions of dollars]

	1988	1989	1990	1991	1992
Sec. 102 Provisions					
Changing the requirements for coinsurance on SNF stays, and covering up to 150 days a year:					
Budget authority	−10.0	−30	−55	−85	−120
Outlays	170.0	275	315	350	385
Eliminating the prior hospitalization requirement for coverage of SNF stays:					
Budget authority	(1)	−2	−5	−10	−15
Outlays	0	40	55	65	75
Sec. 103 Provisions					
Eliminating the 210 day limit on hospice benefits:					
Budget authority	(1)	(1)	(1)	(1)	(1)
Outlays	(1)	1	1	1	1
Sec. 104 Provisions					
Changing blood deductible requirements from 3 per spell to 3 a year:					
Budget authority	(1)	−1	−2	−5	−5
Outlays	5.0	8	10	10	11
Sec. 105 Provisions					
Transferring home health benefits to pt. B:					
Effect on pt. A:					
Budget authority	0	130	445	865	1,360
Outlays	0	−2,896	−4,440	−5,106	−5,867
Effect on pt. B:					
Budget authority	0	3,435	4,690	5,270	6,075
Outlays	0	2,896	4,440	5,106	5,867
Sec. 201 Provisions					
Capping pt. B copayments:					
Budget authority	0	2,445	3,760	4,480	5,330
Outlays	0	2,065	3,515	4,310	5,125
Counting costs of certain screening tests toward cap:					
Budget authority	0	35	50	55	70
Outlays	0	30	50	55	65
Sec. 202 Provisions					
Covering catastrophic expenses for prescription drugs:					
Budget authority	0	965	1,890	2,320	2,600
Outlays	0	965	1,890	2,320	2,600
Increasing pt. B premium to cover resulting outlay costs:					
Budget authority	−90.0	−1,085	−2,015	−2,450	−2,740
Outlays	−90.0	−1,085	−2,015	−2,450	−2,740
Additional costs of Medicaid buy-in requirement due to drug benefit:					
Budget authority	0	20	35	55	75
Outlays	0	20	35	55	75
Sec. 203 Provisions					
Providing in-home personal care:					
Budget authority	0	145	285	380	485
Outlays	0	120	270	360	460
Increasing pt. B premium to cover resulting outlay costs:					
Budget authority	0	−120	−270	−360	−460
Outlays	0	−120	−270	−360	−460
Sec. 204 Provisions					
Extending home health benefits to 35 consecutive days:					
Budget authority	0	180	255	285	330
Outlays	0	155	240	275	315

[By fiscal years, in millions of dollars]

	1988	1989	1990	1991	1992
Sec. 205 Provisions					
Increasing limit on payments for outpatient mental health services to $1,000 a year:					
Budget authority	0	100	200	270	350
Outlays	0	85	185	255	335
Indexing limit to MEI:					
Budget authority	0	0	15	25	30
Outlays	0	0	15	25	30
Clarifying classification of medical management services:					
Budget authority	0	70	105	130	155
Outlays	0	65	100	125	150
Sec. 206 Provisions					
Covering costs of influenza vaccine:					
Budget authority	0	45	70	75	80
Outlays	0	40	70	75	80
Increasing pt. B premium to cover resulting outlay costs:					
Budget authority	0	−40	−70	−75	−80
Outlays	0	−40	−70	−75	−80
Sec. 208 Provisions					
Requiring state Medicaid programs to buy-in all Medicare beneficiaries with incomes below the Federal poverty line:					
Budget authority	70.0	360	425	490	535
Outlays	70.0	360	425	490	535
Sec. 209 Provisions					
Adjusting pt. B premium:					
Budget authority	−5.0	−65	−375	−610	−690
Outlays	−5.0	−65	−375	−610	−690
Sec. 214 Provisions					
Protecting community spouses from impoverishment:					
Budget authority	180.0	310	330	350	375
Outlays	180.0	310	330	350	375
Restricting transfer of assets:					
Budget authority	−125.0	−135	−145	−155	−165
Outlays	−125.0	−135	−145	−155	−165
Medicaid Savings					
Effects of Medicare provisions on Federal Medicaid costs:					
Budget authority	−80.0	−370	−555	−660	−780
Outlays	−80.0	−370	−555	−660	−780
Total direct spending/offsetting receipts:					
Budget authority	−106.0	6,245	8,778	10,200	12,430
Outlays	1,025	4,140	5,735	6,725	7,895
AMOUNTS SUBJECT TO APPROPRIATIONS					
Sec. 201 Provisions					
Administrative costs to implement copayment cap: Outlays	30.0	30	20	20	20
Notice to physicians for enrollees above the cap: Outlays	0	1	1	1	1
Sec. 202 Provisions					
Administrative costs for drug benefit: Outlays	90.0	120	125	130	135
Sec. 207 Provisions					
Annual notice to enrollees of benefits under Medicare (half from HI; half from SMI): Outlays	4.0	4	4	4	4

[By fiscal years, in millions of dollars]

	1988	1989	1990	1991	1992
Mailing directories of participating physicians to all enrollees: Outlays	25.0	25	25	25	25
Sec. 213 Provisions					
Providing research funding on long-term care (half from HI; half from SMI): Outlays	5.0	5	5	5	5
Sec. 308 Provisions					
Authorization of appropriations for commission on comprehensive health care: Outlays	1.5	0	0	0	0
Total amounts subject to appropriations: Outlays	156.0	185	180	185	190
REVENUES					
Sec. 106 Provisions					
Imposing an income-related supplemental premium: [2] Revenues	1,421.0	5,018	5,888	6,641	7,550
Total:					
Budget authority	−106.0	6,245	8,778	10,200	12,430
Outlays	1,181.0	4,325	5,915	6,910	8,085
Revenues	1,421.0	5,018	5,888	6,641	7,550
Change in deficit	−241.0	−693	27	269	535

[1] Less than $0.5 million.
[2] Estimates are from the Joint Committee on Taxation.

Note.—Components may not sum to total due to rounding. The effects of this bill fall within function 570 and function 550.

Basis of estimate: Under current law, Part A of Medicare (Hospital Insurance) pays most of the costs for Medicare-covered services provided by hospitals, skilled nursing facilities (SNFs), home health agencies, and hospices. Enrollees share the costs of services through a variety of copayment requirements, most of which are related to the first-day hospital deductible amount (which was $520 in 1987). Part B of Medicare (Supplementary Medical Insurance) pays for services provided by physicians, independent laboratories, and hospital outpatient departments. Under current law, SMI enrollees are responsible for the first $75 of covered medical expenses, plus 20 percent of all reasonable charges above the deductible amount.

Title I of H.R. 2470 would change the HI copayment requirements, generally effective January 1, 1988, with the result that Medicare's reimbursement costs would increase. It would also change the way in which the HI premium is calculated, which would affect only those enrollees not already entitled to HI benefits through previous payroll tax contributions. Title II of H.R. 2470 would alter copayment requirements under Part B of Medicare by capping each enrollee's annual liability for copayments, first effective for calendar year 1989. It would also provide for expansion of mental health and home health benefits under Medicare, and for additional benefits under Medicaid.

This amendment to H.R. 2470 would not affect Title I. It would be a substitution for Title II. It would provide new benefits under both Medicare and Medicaid in addition to those contained in the original bill. It would also require higher increases in the SMI premium to finance the additional benefits.

Estimates of the costs to Medicare from the copayment provisions of this bill were derived by simulating the effects of proposed changes on a 1 percent random sample of Medicare enrollees (about 300,000 enrollee records). Medicare reimbursement and copayment costs for these enrollees in 1985 under current law were aged to 1988 through 1992, using CBO's baseline projections for enrollment and reimbursements, separately for each major service category. Total Medicare reimbursements under current law were compared to what reimbursements would be after implementation of the proposed provisions to obtain the estimated costs of the benefit expansion.

Under current law, Medicare reimbursements per enrollee are projected to increase by about 9.6 percent annually between 1987 and 1992. Under this amendment bill, reimbursements per enrollee would increase by an estimated 11.4 percent annually over the same period. About 70 percent of the additional Medicare benefit costs would be due to the assumption by Medicare of some enrollees' copayment liabilities for current services. The remaining 30 percent of estimated costs would be due to increases in Medicare-covered services, due partly to expanded coverage and partly to increased use of services by enrollees in response to reduced cost-sharing. The utilization responses assumed in the estimates were based on regression analyses of health care use by Medicare enrollees with and without supplementary insurance coverage for their Medicare copayment costs, using 1984 Health Insurance Survey data.

The revenue estimates for the income-related premiums were obtained from the Joint Committee on Taxation, and were based on simulations on a stratified random sample of current income tax returns, projected through 1992.

The specific provisions of the bill are explained in detail below. Unless otherwise indicated, the Title I provisions would take effect on January 1, 1988, and the Title II provisions would take effect on January 1, 1988.

Direct spending/offsetting receipts

Section 101 provisions

Section 101 of the bill contains five provisions, discussed in turn below. The estimates in this section take account of Medicare's additional reimbursements to hospitals to compensate for Medicare enrollees' bad debt—that is, the failure by some enrollees to pay the deductible and coinsurance amounts for which they are liable. Estimates by the Inspector General of the Department of Health and Human Services indicate that about 4 percent of enrollees' copayment liabilities for hospital stays are bad debt, which is eventually paid by Medicare.

Eliminating the limit on covered hospital days: Under current law, Medicare will cover up to 90 days during each spell of illness, plus an additional lifetime reserve of up to 60 days. In addition, there is a lifetime reserve of 190 days for inpatient psychiatric care. This bill would eliminate the limit on covered hospital days for general care, but would retain the lifetime limit for inpatient psychiatric care. Only a fraction of a percent of enrollees (fewer

than 0.1 percent) exhaust their hospital benefits for general inpatient care each year, but the costs such patients incur are substantial. Covering these days would cost Medicare $180 million in fiscal year 1988. This estimate is based on information provided by the Health Care Financing Administration, indicating that this provision would add about 0.5 percent to total inpatient costs of Medicare-covered inpatient stays.

Eliminating enrollees' copayments for hospital coinsurance and reserve days: Under current law, enrollees pay one-fourth of the first-day hospital deductible amount for days 61–90 in a given spell of illness (coinsurance days), and one-half of the deductible amount for any lifetime reserve days used. This bill would eliminate enrollees' liability for coinsurance and reserve days. About 0.5 percent of HI enrollees use coinsurance or reserve days each year, accounting for an estimated 23 million coinsurance day and 0.7 million reserve days in 1988. Eliminating these inpatient coinsurance costs would cost Medicare $295 million in fiscal year 1988.

Limiting payment of the hospital deductible to the first stay each calendar year: Under current law, enrollees are liable for a hospital deductible each time they are admitted to the hospital in a new spell of illness (which begins on the 61st day following discharge from a previous inpatient episode). In 1988, about 800,000 enrollees will pay more than one first-day deductible under current law, while no one would be liable for more than one deductible each year under this bill. In addition, the bill contains a hold-harmless provision that would protect enrollees who were readmitted after January 1, 1988, within a spell of illness that had begun prior to that date from paying another deductible for such admissions. These provisions would cost Medicare an estimated $395 million in fiscal year 1988.

Indexing the first-stay hospital deductible to the COLA: Under current law, the first-day deductible is tied to increases in the index used to update payment rates under the prospective payment system. Under this bill, the deductible would instead be tied to increases in the (third-quarter) consumer price index (the Social Security COLA). This would slow the rate of growth in the deductible, because the update factor is projected to increase by 35 percent from 1987 to 1992, while the COLA is projected to increase by only 23 percent over the same period. In 1988, the deductible would be $544 under current law, but would be $541 if indexed to the COLA instead. By 1992, the deductible would increase to $700 under current law, but would be only $641 if indexed to the COLA. The additional costs to Medicare of this provision (after implementing all of the inpatient copayment provisions discussed above, as well as the SNF copayment provision discussed above) would be an estimated $10 million in fiscal year 1988.

Changing the calculation of the Part A premium: Under current law, the premium charged to HI enrollees who are not entitled to benefits through previous payroll tax contributions is based on the first-day deductible amount. Under this bill, the method of determining the premium would be charged so that it would reflect the actuarial value of HI benefits. This would reduce the projected monthly premium amount for 1988 from $236 to $155, affecting

about 23,000 enrollees. The costs to Medicare from this provision in fiscal year 1988 would be about $15 million.

Section 102 provisions

Section 102 contains provisions relating to Medicare coverage of stays in skilled nursing facilities (SNFs). They would change coinsurance requirements, provide for coverage of up to 150 days a year, and eliminate the 3-day prior hospitalization requirement for covered SNF care.

Changing the requirements for coinsurance on SNF stays, and covering up to 150 days a year: The bill would alter the way in which enrollees' coinsurance liability for stays in skilled nursing facilities is determined, and would change Medicare's coverage limits from 100 days per spell to 150 days a year. Under current law, coinsurance amounts equal to one-eighth of the hospital deductible amount ($68 per day in 1988) are charged each day for days 21–100 in SNFs during each spell of illness. Under the bill, enrollees would pay coinsurance amounts equal to 20 percent of Medicare's national average reasonable cost for the first seven days of each SNF stay; enrollees' coinsurance costs would be $23.50 per day in 1988 for each of the first seven days of each SNF stay.

Fewer than 2 percent of Medicare enrollees have covered SNF stays, but these enrollees will use about 8.6 million SNF days during 1988. These provisions would increase Medicare costs by $170 million in fiscal year 1988. About 80 percent of the costs would be due to lower coinsurance amounts paid by enrollees, while the remaining 20 percent of costs would be due to additional covered SNF days resulting from the change in coverage limits to 150 days a year. The estimate assumes that those enrollees who would exhaust their SNF coverage under current law (about 7,500 in 1988) would use the full 150 days allowed under the bill.

Eliminating the prior hospitalization requirement for SNF stays: This bill would remove the requirement that a Medicare enrollee be hospitalized for at least three days prior to admission to a SNF to be eligible for Medicare coverage, effective January 1, 1989. As a result, the number of people receiving the SNF benefit would increase. Increased costs resulting from this provision are estimated at $40 million for fiscal year 1989, based on findings from a demonstration and study conducted by the Health Care Financing Administration.

Section 103 provisions

Section 103 of the bill would eliminate the current 210-day lifetime limit on the number of days enrollees who are terminally ill may receive hospice services. Nearly 98 percent of hospice beneficiaries die before the 210-day limit is reached, but tabulations by the Health Care Financing Administration indicate that those who survive for the full 210 days of their hospice benefit live another 50 days, on average. Because not all of these additional Medicare costs under the hospiced benefit would be offset by reduced costs for inpatient, SNF, or home health services, there would be a small costs due to this provision, equal to about $0.4 million in fiscal year 1988.

Section 104 provisions

Under current law, enrollees are required to replace or pay for the first 3 pints of blood used each spell of illness. Section 5 of the bill would require enrollees to replace or pay for the first 3 pints of blood used each year. Medicare costs would increase under this provision because enrollees would pay for an estimated 156,000 fewer pints of blood used in 1988 than they would under current law, costing Medicare about $50 per pint. The additional costs to Medicare in fiscal year 1988 would be about $5 million.

Section 105 provisions

This section of the bill would transfer the financing for home health benefits from the HI trust fund to the SMI trust fund for all Part B enrollees, effective January 1, 1989. Medicare beneficiaries who are not enrolled under Part B could continue to receive home health benefits under Part A. This would generate no net outlay costs, but it would alter budget authority totals under the two trust funds.

Section 201 provisions

Capping Part B copayments: Under Section 201 of the bill, each SMI enrollee's liability for copayments under the program would be capped at $1,043 in 1989. In subsequent years, the value of the copayment cap would increase at the same rate as the third-quarter Consumer Price Index (the Social Security COLA). Under CBO's baseline projections, the COLA would increase by about 4 percent annually over the five-year projection period, so that the SMI copayment cap would be $1,185 in 1992.

More than 8 percent of SMI enrollees would be affected by the copayment cap in 1989. As a result, SMI benefit costs would increase by $2.1 billion in fiscal year 1989. By 1992, more than 10 percent of enrollees would be affected by the copayment cap, at a cost to Medicare of $5.1 billion during that year.

Counting costs of certain screening tests toward cap: The costs of annual colorectal examinations for enrollees age 65 or more, and of triennial mammograms for enrollees age 55 or more, would count toward the copayment cap. This would effectively reduce the copayment cap for enrollees who obtained such tests. As a result of this provision, about 70,000 additional enrollees would exceed the copayment cap and a larger share of enrollees' copayment costs would be assumed by Medicare for all enrollees above the cap. The incremental costs of this provision would be an estimated $30 million in fiscal year 1989.

Section 202 provisions

Covering catastrophic expenses for prescription drugs: Under current law, Medicare generally pays only for immunosuppressive drugs in the first year following a covered transplant operation. This section of the bill would expand Part B coverage to include all reasonable costs for prescription drugs above a deductible amount, which would be set at $500 for calendar year 1989 and indexed to the medical care component of the consumer price index (CPI–M) thereafter. The deductible amount for the drug benefit would not

count toward the SMI copayment cap. About 17 percent of SMI enrollees would benefit from this provision in 1989, at an estimated benefit cost of $965 million for the fiscal year. Details on estimation of the benefit costs are discussed here. There would be additional administrative costs as well, discussed in the section on amounts subject to appropriations.

Because the proposal involves a deductible amount, it is necessary to estimate not only total spending by Medicare enrollees on prescription drugs, but also how that spending is distributed among enrollees and what proportion of enrollees who would exceed the deductible amount would actually file for reimbursement. Each of these components is explained below.

Total spending on drugs by Medicare enrollees: The CBO estimate of 1988 annual per capita prescription drug spending by Medicare enrollees of $250 was based on data from the Consumer Expenditure Survey (CES)—a 1984 survey of household spending from the Bureau of Labor Statistics. The CES shows that per person spending for prescription drugs in households headed by an elderly person was $137 in 1984. This figure was adjusted to reflect the age composition of households and direct purchases of drugs by third parties. This adjusted estimate of spending per elderly person was projected to average $268 in 1989 and $331 in 1992, based on published forecasts of drug expenditures from the Health Care Financing Administration.

Distribution of spending: CBO estimates that 5.5 million Medicare beneficiaries—16.9 percent—would exceed a deductible of $500 on prescription drugs in 1989. This estimate is based on data from the 1977 Current Medicare Survey (CMS), a survey of about 5,000 Medicare beneficiaries. (The 1984 CES household-level expenditure data cannot be used to provide an estimate of how expenditures vary by person.) In order to estimate the 1989 distribution of drug spending, the CMS data were increased proportionately to reflect a mean of $268.

Utilization and spending changes in response to the new benefit: The estimates assume that use of prescription drugs would rise only slightly under this proposal. The small magnitude of this assumed response is based on two factors: (1) the large deductible and (2) the fact that drug utilization is primarily determined by physicians. Under the proposal only about 17 percent of enrollees would receive Medicare drug benefits. We assume that this deductible level would inhibit the increased use that might occur if, instead, drugs were provided at a lower deductible to a larger proportion of enrollees. Much of the potential induced demand for drugs under insurance is already reflected in baseline spending, because outpatient drugs are prescribed during physician visits. Since Medicare enrollees are already well insured for physicians' services under Medicare, Medicaid, and medigap policies, the addition of the proposed drug coverage would be expected to have little effect on prescription drug use.

Because several studies have estimated that up to 4 percent of all drugs that are dispensed to the elderly are provided free, this estimate assumes that many of these drugs no longer would be provided free to enrollees once Medicare reimbursement was available. A

spending increase of 2 percent was included in the estimate to reflect payment for previously free prescriptions by Medicare.

Participation rate: The bill requires that enrollees and/or pharmacists initiate the request for reimbursement, once the deductible has been exceeded. Those who use more than one pharmacist or who shop at nonparticipating pharmacies would have to request that the pharmacists add their prescription costs and forward them to the government. For a variety of reasons, some enrollees will not make this request and some pharmacies will not report all drug expenditures. For example, persons who are covered by employer-based insurance or who exceed the deductible by small amounts would have little motivation to apply for reimbursement. Hence, we assume that only 85 percent of eligible costs will actually be reimbursed.

Reimbursement limits: The bill would reimburse drugs at the lower of three limits: the actual charge, the average wholesale cost plus a $4.50 dispensing fee, or 125 percent of the cost of the lowest available generic drug plus a $4.50 dispensing fee. The dispensing fee would be indexed to the CPI–M.

The effect of several of these limits on reimbursement is clear. The requirement for setting reimbursement at the lowest available generic drug price would reduce reimbursement. The effect of the generic limit was based on data from the Food and Drug Administration, discussions with representatives of the Pharmaceutical Manufacturers Association and a variety of other experts. Based on these data and discussions, it appears that approximately one-half of all drugs sold have a generic equivalent, average markup of drugs by pharmacies appears to be approximately 40 percent, and the market share represented by generic drugs is increasing at a rapid rate. Given these factors, we estimated savings from the generic limit of 10 percent per year.

Increasing the Part B premium to cover resulting outlay costs: This bill would require all of the expected increase in outlays for the drug benefit to be funded by an increase in the Part B premium. Currently, Part B premiums are based on incurred reimbursement costs per aged Medicare enrollees and pay only about 25 percent of those costs. Outlay estimates were obtained by adjusting incurred expenditures to allow for lags in payment, which are due to claims processing time and the delay in claim submissions. The monthly premium increase required by the drug benefit would be an estimated $0.30 in 1988, $3.60 in 1989, $5.60 in 1990, $6.30 in 1991, and $6.80 in 1992.

Additional costs of Medicaid buyin requirement due to drug benefit: Under a later provision of this amended bill, Medicaid programs would be required to pay SMI premiums and Medicare copayment costs for all poor Medicare enrollees who satisfy specified income and assets tests. This drug benefit would generate additional costs under the buyin requirement, which would equal an estimated $20 million in fiscal year 1989.

Section 203 provisions

Providing in-home personal services: Under current law, Medicare pays only for medical services under the home health benefit. This section of the bill would provide for coverge of up to 120 hours

each year for in-home personal services for chronically dependent enrollees who could not be left alone in their homes, at an estimated cost of $120 million in fiscal year 1989.

Increasing the Part B premium to cover resulting outlay costs: The SMI premium would be increased by an amount projected to cover all additional costs under this new in-home benefit. The required additional monthly premiums—for this benefit alone—would be an estimated $0.40 in 1989, and $0.80 in 1990.

Section 204 provisions

Currently, Medicare enrollees are entitled to receive two to three weeks of daily home health visits. This bill would increase the limit to 35 days, and would clarify current law by specifying that "daily care" means up to 7 days a week. The estimated cost of this provision, which would be effective January 1, 1989, is $155 million for fiscal year 1989. The estimate is based on Medicare administrative data on the distribution of home health visits under current law, and on projections of the increased utilization that would result from clarifying the definition of daily care and increasing the limit on consecutive days.

Section 205 provisions

Increasing limit on outpatient mental health services: Current law limits reimbursement for outpatient mental health services to $250 a year per enrollee. This bill would increase the limit to $1,000 a year, effective for calendar year 1989. The coinsurance rate on the additional benefits would remain at 50 percent, as under current law, and the additional copayments resulting from this provision would not count toward the SMI copayment cap described elsewhere in this bill. The estimated costs for this provision are $85 million in fiscal year 1989. The estimate is based on current use rates for the mental health benefit and projected increases in utilization due to the higher limit. The estimates of increased utilization were based on results of a demonstration study of a similar benefit expansion conducted by the Department of Health and Human Services.

Indexing limit to MEI: The additional costs of indexing the mental health limit to the Medicare Economic Index, so that the $1,000 limit on mental health reimbursements for 1989 would grow to an estimated $1,120 by 1992, would be an estimated $30 million by that year.

Clarifying classification of medical management services: Current law would be clarified so that visits with physicians for medical management services would not be classified as mental health services, and would therefore not be counted toward the reimbursement limit for outpatient mental health services. The costs of this provision would be an estimated $65 million in fiscal year 1989.

Section 206 provisions

Covering costs of influenza vaccine: Medicare coverage would be expanded to include 100 percent of the reasonable costs of administration of influenza vaccine. An estimated 8.5 million enrollees would benefit from this provision, at a cost of $40 million in fiscal year 1989.

Increasing the Part B premium to cover resulting outlay costs: The SMI premium would be increased by an amount projected to cover all additional outlay costs under this influenza vaccine benefit. The required additional monthly premium—for this benefit alone—would be an esimated $0.10 in 1989, and $0.20 in 1990.

Section 208 provisions

Currently, state Medicaid programs may choose whether or not to pay Medicare premium and copayment costs for all Medicare enrollees with incomes below the poverty level. This bill would require states to cover these costs, thereby affecting approximately 46 states that do not currently provide this Medicaid benefit to all poor Medicare enrollees, effective July 1, 1988.

This differs from a similar provision under the original Title II for several reasons. First, the definition of poverty that would be used under the amended bill would be current federal poverty guidelines (published by the Office of Management and Budget) rather than those published by the Census Bureau for the second previous calendar year. Second, the asset test used under the amended bill would be twice as large as that specified under the original bill. Finally, this section would retain the linkage between increases in coverage of the elderly and increases in coverage for infants and pregnant women contained in current law.

The estimated costs of this provision are $70 million in fiscal year 1988. The cost estimate is based on counts from the Current Population Survey of poor Medicare enrollees who do not receive Medicaid benefits, and on Medicaid program data showing the current cost of the proposed benefits per Medicare-eligible Medicaid beneficiary.

Section 209 provisions

This section provides for several adjustments to the current-law SMI premium. (The premiums discussed here would be distinct from the new outlay-based premiums intended to finance the new drug, in-home care, and influenza vaccine benefits. Further, those new benefits would not enter into the calculation of insurance values discussed below.)

For most SMI enrollees, the SMI premium would be increased by $1.00 a month in 1990, and by an additional $0.40 a month in 1991, on top of the automatic increases that would result under current law. (Under current law, beginning in 1989 SMI premium increases may not exceed the rate at which Social Security benefits are adjusted each year to offset cost-of-living increases, as measured by the change in the third-quarter Consumer Price Index. This is referred to as the COLA.)

Two groups are exempt from the ad hoc premium increases described above, however, and would be subject to a different set of provisions. For residents of Puerto Rico and the other territories, the current-law SMI premium would be increased in 1988 and 1989 by the insurance value of the new Medicare HI and SMI benefits provided under this bill. For U.S. residents who are enrolled in Part B but who are not eligible for Part A benefits, the current-law SMI premium would be increased in 1989 by the insurance value of the new Medicare SMI benefits provided under this bill. Beginning

in 1990 and for all subsequent years, the premiums paid would be indexed to the COLA.

The net effect of these premium provisions would be to generate additional premium receipts of $5 million in fiscal year 1988, growing to $685 million by fiscal year 1992.

Section 214 provisions

Protecting community spouses from impoverishment: In the case of a couple where one is in a nursing home, this provision is intended to protect the spouse remaining in the community from being impoverished by Medicaid's requirements for coverage of the nursing home stay. It would require that states increase both the assets and the income that the community spouse could retain. These provisions would be effective January 1, 1988. Estimated costs are $180 million in fiscal year 1988.

Restricting transfer of assets: For institutionalized patients applying for Medicaid benefits, the bill would require states to examine the previous 24-month period to determine whether the applicant had transferred assets to others that would otherwise have been available to pay for their nursing home care. If so, eligibility for Medicaid coverage would be delayed. Approximately 18 states currently do this, and all would be required to do so under the bill. Estimated savings would be $125 million in fiscal year 1988.

Federal Medicaid savings

About 9 percent of Medicare enrollees are dually eligible for Medicaid benefits. For these enrollees, Medicaid generally pays both their copayment liabilities under Medicare and their SMI premium costs. Consequently, Medicaid costs would be reduced by this bill because of lower copayment costs for Medicare enrollees, partially offset by increased Medicaid costs for the higher SMI premiums. In addition, there would be some additional savings to Medicaid in states with "medically needy" programs because the copayment limitations provided under this bill would reduce the number of Medicare enrollees who would qualify for Medicaid benefits under such programs. Savings are estimated to be $80 million in fiscal year 1988.

Amounts subject to appropriations

Section 201 provisions

Administrative costs to implement copayment cap: Neither Medicare carriers nor the Health Care Financing Administration currently collect information on the amounts of coinsurance paid by enrollees for Part B benefits. To implement the copayment cap propopsed in this bill, comprehensive information about both deductible and coinsurance amounts paid under Part B would have to be compiled across all Medicare carriers for each SMI enrollee. The estimates of start-up and ongoing administrative costs under this proposal are based on discussions with the Bureau of Program Operations in the Health Care Financing Administration.

Notice to physicians for enrollees above the cap: The bill would require carriers to notify physicians serving enrollees whose copayment costs had exceeded the SMI copayment cap, encouraging

them to accept assignment on all subsequent claims for enrollees. The costs of this provision are estimated at $1 million each year.

Section 202 provisions

Administrative costs for drug benefit: Administrative costs for the drug benefit would be composed of startup costs, fixed ongoing costs, and claims processing costs. These would total $90 million for fiscal year 1988, growing to $135 million by 1992.

The costs for 1988 are entirely startup costs, necessary to finance the costs of hiring and training personnel, development and installation of computer hardware and software, and activities necessary to enroll pharmacists. Fixed ongoing costs would be used to increase central and regional Health Care Financing Administration office staff, to establish and maintain a nationwide data base of drug costs for enrollees, and to undertake utilization control and quality monitoring activities. Costs for claims processing would vary based on the number of claims that were processed, and on whether the claims were electronically submitted or not. In 1989, the estimated processing cost per claim is $1.20, and the estimate assumes that 33 million claims (for 50 million prescriptions) would be processed.

Section 207 provisions

Annual notice of benefits: Under this provision, the Department of Health and Human Services would be required annually to mail each HI or SMI enrollee an explanation of Medicare benefits, beginning with calendar year 1988. The funds would be taken equally from the HI and the SMI trust funds. Estimated costs for this provision are $4 million annually, based on previous experience with such mailings by the Social Security Administration and by the Health Care Financing Administration.

Participating physicians directories: In addition, the Department would be required to mail annually a directory of participating physicians to each SMI enrollee, beginning calendar year 1988. The costs of this provision are estimated to be $25 million a year, again based on previous experience by the Social Security and the Health Care Financing administrations.

Section 213 provisions

Section 213 would authorize an appropriation of $5 million annually for each year from 1988 through 1992, to conduct research on long term care services for Medicare enrollees. The funds would be taken equally from the HI and the SMI trust funds.

Section 308 provisions

The bill would create a Bipartisan Congressional Commission to make recommendations to the Congress on improving access to comprehensive health care services. The Commission would be charged to deliver two reports within a year of its creation—one on long-term care for the aged and disabled, and one on comprehensive health care for all Americans. It would be disbanded following release of these two reports. The bill authorizes an appropriation of $1.5 million for the Commission.

Revenues

Section 106 provisions

This section would impose an income-related, tax-based supplementary premium on all people eligible for benefits under Part A of Medicare, excluding nonresidents, effective January 1, 1988. For individuals who were eligible for only part of the year, this supplementary premium would be pro-rated for the part of year during which they were Medicare-eligible. The supplementary premium rates would be indexed to the rate of growth in the subsidy value of Medicare benefits. The Joint Tax Committee estimates that revenues from this income-related premium would total $1.4 billion in fiscal year 1988.

6. Estimated costs to State and local governments: This bill would have an effect on state and local government budgets, because of the savings that would accrue to state Medicaid programs from the new Medicare benefits and because of the requirements that states expand Medicaid benefits. The net effect is shown below.

[By fiscal years, in millions of dollars]

	1988	1989	1990	1991	1992
Effects of State/local Medicaid costs	140	260	190	190	170

7. Estimate comparison: None.

8. Previous CBO estimates: On May 20, 1987, CBO provided an estimate for H.R. 2470, the Medicare Catastrophic Protection Act of 1987, as ordered reported by the Ways and Means Committee. H.R. 2470 was then referred to the Energy and Commerce Committee which has made a number of amendments. The major changes from the Ways and Means bill include covering catastrophic expenses for prescription drugs, providing in-home personal care, and covering the costs of influenza vaccines—together with increases in the Part B premium to cover the outlay costs of these activities. The Energy and Commerce Committee would also count the costs of certain screening tests toward the catastrophic cap in Part B. Finally, the Energy and Commerce Committee has added to Medicaid provisions to protect community spouses from impoverishment and to limit the transfer of assets in order to qualify for Medicaid benefits, and altered a third Medicaid provision requiring all states to pay the Medicare premium and copayment costs for Medicare enrollees with incomes below the poverty line.

Over the past several weeks, the CBO has made a number of estimates of proposals that would have Medicare insure some prescription drug spending by its enrollees. In response to comments from the Administration and others, our data bases and estimating procedures have been improved. In particular, the data on which we base the mean and distribution of current law prescription drug spending have been changed, with two implications—the current methods result in what we believe to be better estimates and earlier estimates have been changed to reflect these improvements.

9. Estimate prepared by: Sandra Christensen, Holly Harvey, Don Muse, and Jack Rodgers.

10. Estimate approved by: C.G. Nuckols, for James L. Blum, Assistant Director for Budget Analysis.

Inflationary Impact Statement

Pursuant to clause 2(l)(4) of rule XI of the Rules of the House of Representatives, the Committee makes the following statement with regard to the inflationary impact of the reported bill:

The Committee believes that the bill as reported will not have a significant effect on health care costs or the general economy. Medicare enrollees will receive greater protection against the financial risks of prolonged illnesses or catastrophic injuries, but will finance this protection out of increased premiums. The bill includes measures to control the costs of expanded benefits.

Agency Views

The Secretary of Health and Human Services,
Washington, DC, June 15, 1987.

Hon. John D. Dingell,
Chairman, Committee on Energy and Commerce, House of Representatives, Washington, DC.

Dear Mr. Chairman: When the President announced in his State of the Union message this year that he would transmit to the Congress legislation providing for acute care, catastrophic coverage under the Medicare program, a dialogue began which emphasizes the substantial consensus across the Nation for providing the elderly with this protection. Indeed, the debate thus far has centered largely—not on whether to provide this protection—but on how to accomplish this goal.

Unfortunately, we are most concerned that unanimity on the need for the legislation could be jeopardized by the content of the bills currently being debated by the Ways and Means and Energy and Commerce Committees. These bills contort the concept the President endorsed: to provide an acute care, catastrophic benefit under Medicare. Instead, it appears that the legislation has become a vehicle for modifications and add-ons to the basic Medicare program.

Enactment of legislation of the variety currently under consideration in the Congress will result in a cruel hoax on the intended beneficiaries. These program add-ons, combined with the lower out-of-pocket threshold, result in program cost increases that quickly outpace the bill's financing, greatly jeopardizing the stability of the program's design. The elderly will once again be faced with uncertainty as to the dependability of their coverage. This Administration will not tolerate that result.

Preliminary estimates by the Medicare actuary and Treasury indicate that even without the estimated $7–9 billion annual cost of a drug benefit, by 1993 the House bill's program costs will exceed revenues, with a shortfall of close to $10 billion likely by the year 2000. I know that every member of the Committee shares the Administration's concern that this coverage must be self-financing

and budget-neutral. Given current projections as to the future solvency of the Medicare trust funds, such a shortfall would threaten Medicare itself—a truly catastrophic event this Administration cannot allow.

This Administration has continually expressed its opposition to the financing mechanism contained within H.R. 2470, the Medicare Catastrophic Protection Act of 1987. We prefer the Administration's premium approach that avoids the serious problems created when the financing for an insurance program is tied to the tax code.

The bill which emerged from the Ways and Means Committee contained a number of disturbing add-ons to the concept of a catastrophic health care proposal.

When H.R. 2470 was approved by the Energy and Commerce Health Subcommittee, the list of expansions grew even longer, as the Subcommittee added: a costly, new drug benefit; a new, in-home care benefit for homemaker services; a further expansion of the Ways and Means expansion for mental health coverage; and others. The merits of these proposals to the Medicare program can be debated, but this is not the appropriate vehicle on which to place additional and worrisome costs that will eventually threaten the entire Medicare program.

We strongly oppose the addition of a new drug benefit to the Medicare program. Our actuaries have estimated that the Ways and Means approach to the drug benefit could cost *$7 billion* the first year alone, and the Energy and Commerce approach *$9 billion.* Even if either of these provisions were to be enacted, this benefit could not be administered through Medicare until January 1989, or perhaps 1990, at the earliest. We believe that the administrative problems would be immense. Much further analysis is required before the Administration could even recommend an appropriate strategy.

Inclusion in the legislation of several provisions alone could cause recommendation of a veto, namely the mandated Medicaid buy-in, which impinges on an area best left to the States, and the well-intentioned but ill-advised drug benefit, which—if it could be crafted—would run into billions of dollars in expenditures per year.

While we continue to stand enthusiastically behind our desire to enact a catastrophic health care program to ensure this Nation's elderly against devastating acute illnesses, that is not what the legislation currently before the Congress has become.

Should this legislation reach the President's desk in its current form, other senior advisers and I would be forced to recommend a veto. This is not a step we would take lightly, for we are committed to providing the elderly and disabled with this catastrophic protection.

I strongly urge that you reconsider the direction in which this legislation is headed and steer it back toward our original goal of providing catastrophic health care insurance for the elderly and disabled. We are advised by the Office of Management and Budget

that enactment of H.R. 2470 would not be in accord with the program of the President.

Sincerely,

OTIS R. BOWEN,
Secretary.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

* * * * * * *

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * * * *

NOTICE OF MEDICARE BENEFITS

SEC. 1804. (a) The Secretary shall distribute annually a notice containing—

(1) a clear, simple explanation of the benefits available under this title and health care services for which benefits are not available under this title, and

(2) a description of the limited benefits for long-term care services available under this title and generally available under State plans approved under title XIX.

Such notice shall be mailed annually to individuals entitled to benefits under part A or part B of this title.

(b) There are authorized to be appropriated in equal proportions from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund such sums as may be required to provide for the annual publication and distribution of the notice described in subsection (a).

* * * * * * *

PART A—HOSPITAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

DESCRIPTION OF PROGRAM

SEC. 1811. The insurance program for which entitlement is established by section 226 and 226A provides basic protection against the costs of [hospital, related post-hospital] *inpatient hospital services, extended care services* home health services, and hospice care in accordance with this part for (1) individuals who are age 65 or over and are eligible for retirement benefits under title II of this Act (or would be eligible for such benefits if certain government employment were covered employment under such title) or under the railroad retirement system, (2) individuals under age 65 who have been entitled for not less than 24 months to benefits under

title II of this Act (or would have been so entitled to such benefits if certain government employment were covered employment under such title) or under the railroad retirement system on the basis of a disability, and (3) certain individuals who do not meet the conditions specified in either clause (1) or (2) but who are medically determined to have end stage renal disease.

SCOPE OF BENEFITS

SEC. 1812. (a) The benefits provided to an individual by the insurance program under this part shall consist of entitlement to have payment made on his behalf or, in the case of payments referred to in section 1814(d)(2) to him (subject to the provisions of this part) for—

[(1) inpatient hospital services for up to 150 days during any spell of illness minus 1 day for each day of inpatient hospital services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of the Secretary that he does not desire to have such payment made);]

(1) inpatient hospital services;

(2) [(A) post-hospital] extended care services for up to [100 days during any spell of illness, and (B) to the extent provided in subsection (f), extended care services that are not post-hospital extended care services] *150 days during any calendar year;*

(3) *subject to subsection (f),* home health services; and

(4) in lieu of certain other benefits, hospice care with respect to the individual during up to two periods of 90 days each [and one], a subsequent period of 30 days, *and a subsequent extension period* with respect to which the individual makes an election under subsection (d)(1).

(b) Payment under this part for services furnished an individual [during a spell of illness may not (subject to subsection (c))] *may not* be made for—

[(1) inpatient hospital services furnished to him during such spell after such services have been furnished to him for 150 days during such spell minus 1 day for each day of inpatient hospital services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of the Secretary that he does not desire to have such payment made);]

[(2) post-hospital] *(1)* extended care services furnished to him [during such spell after such services have been furnished to him for 100 days during such spell] *during a calendar year after such services have been furnished to the individual for 150 days during that year;* or

[(3)] *(2)* inpatient psychiatric hospital services furnished to him after such services have been furnished to him for a total of 190 days during his lifetime.

[(c) If an individual is an inpatient of a psychiatric hospital on the first day of the first month for which he is entitled to benefits

under this part, the days on which he was an inpatient of such a hospital in the 150-day period immediately before such first day shall be included in determining the number of days limit under subsection (b)(1) insofar as such limit applies to (1) inpatient psychiatric hospital services, or (2) inpatient hospital services for an individual who is an inpatient primarily for the diagnosis or treatment of mental illness (but shall not be included in determining such number of days limit insofar as it applies to other inpatient hospital services or in determining the 190-day limit under subsection (b)(3)).]

(c)(1) If an individual is an inpatient of a psychiatric hospital on the first day of medicare entitlement (as defined in paragraph (4)(A)) payment may not be made under this part during the period described in paragraph (2) for inpatient mental health services (as defined in paragraph (4)(B)) in excess of the number of days specified in paragraph (3).

(2) The period described in this paragraph—

(A) begins on the first day of medicare entitlement, and

(B) ends at the end of the first period of 60 consecutive days thereafter on each of which the individual is not receiving inpatient mental health services.

(3) The number of days specified in this paragraph for an individual is 150 days less the number of days (during the 150-day period immediately before the first day of medicare entitlement) during which the individual was an inpatient of a psychiatric hospital.

(4) In this subsection:

(A) The term "first day of medicare entitlement" means, for an individual, the first day of the first month for which the individual is entitled to benefits under this part.

(B) The term "inpatient mental health services" means—

(i) inpatient psychiatric hospital services, and

(ii) inpatient hospital services for an individual who is an inpatient primarily for the diagnosis or treatment of mental illness.

(d)(1) Payment under this part may be made for hospice care provided with respect to an individual only during two periods of 90 days each [and one subsequent period of 30 days], *a subsequent period of 30 days, and a subsequent extension period* during the individual's lifetime and only, with respect to each such period, if the individual makes an election under this paragraph to receive hospice care under this part provided by, or under arrangements made by, a particular hospice program instead of certain other benefits under this title.

(2)(A) * * *

(B) After an individual makes such an election with respect to a 90- or 30-day period *or a subsequent extension period* the individual may revoke the election during the period in which case—

(i) * * *

* * * * * * *

(e) For purposes of subsections (b) and (c), inpatient hosptial services, inpatient psychiatric hospital services, and [post-hospital] extended care services shall be taken into account only if payment is or would be, except for this section or the failure to comply with

the request and certification requirements of or under section 1814(a), made with respect to such services under this part.

[(f)(1) The Secretary shall provide for coverage, under clause (B) of subsection (a)(2), of extended care services which are not post-hospital extended care services at such time and for so long as the Secretary determines, and under such terms and conditions (described in paragraph (2)) as the Secretary finds appropriate, that the inclusion of such services will not result in any increase in the total of payments made under this title and will not alter the acute care nature of the benefit described in subsection (a)(2).

[(2) The Secretary may provide—

[(A) for such limitations on the scope and extent of services described in subsection (a)(2)(B) and on the categories of individuals who may eligible to receive such services, and

[(B) notwithstanding sections 1814, 1861(v), and 1886, for such restrictions and alternatives on the amounts and methods of payment for services described in such subsection, as may be necessary to carry out paragraph (1).

[(g) For definition of "spell of illness", and for definitions of other terms used in this part, see section 1861.]

(f) Subsection (a)(3) shall only apply to home health services provided to an individual during a month in which the individual is not entitled to benefits under part B.

DEDUCTIBLES AND COINSURANCE

SEC. 1813. (a)(1) The amount payable for inpatient hospital services furnished an individual during [any spell of illness] *the first period of continuous hospitalization (as defined in subsection (b)(3)) that begins in a calendar year* shall be reduced by a deduction equal to the inpatient hospital deductible *for that calendar year* or, if less, the charges imposed with respect to such individual for such services, except that, if the customary charges for such services are greater than the charges so imposed, such customary charges shall be considered to be the charges so imposed. [Such amount shall be further reduced by a coinsurance amount equal to—

[(A) one-fourth of the inpatient hospital deductible for each day (before the 91st day) on which such individual is furnished such services during such spell of illness after such services have been furnished to him for 60 days during such spell; and

[(B) one-half of the inpatient hospital deductible for each day (before the day following the last day for which such individual is entitled under section 1812(a)(1) to have payment made on his behalf for inpatient hospital services during such spell of illness) on which such individual is furnished such services during such spell of illness after such services have been furnished to him for 90 days during such spell;

except that the reduction under this sentence for any day shall not exceed the charges imposed for that day with respect to such individual for such services (and for this purpose, if the customary charges for such services are greater than the charges so imposed, such customary charges shall be considered to be the charges so imposed.]

[(2) The amount payable to any provider of services under this part for services furnished an individual during any spell of illness shall be further reduced by a deduction equal to the cost of the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to him as part of such services during such spell of illness.]

(2)(A) The amount payable to any provider of services under this part for services furnished an individual shall be further reduced by a deduction equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during each calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence.

(B) The deductible under subparagraph (A) for blood or blood cells furnished an individual in a year shall be reduced to the extent that a deductible has been imposed under section 1833(b) to blood or blood cells furnished the individual in the year.

[(3) The amount payable for post-hospital extended care services furnished an individual during any spell of illness shall be reduced by a coinsurance amount equal to one-eighth of the inpatient hospital deductible for each day (before the 101st day) on which he is furnished such services after such services have been furnished to him for 20 days during such spell.]

(3)(A) The amount payable for extended care services furnished an individual in any calendar year shall be reduced by the coinsurance amount (promulgated under subparagraph (C) for that year) for each day (before the 8th day) on which he is furnished such services during the year.

(B) Before September 1 of each year (beginning with 1987), the Secretary shall estimate the national average per diem reasonable cost recognized under this title for extended care services which will be furnished in the succeeding calendar year.

(C) The Secretary shall, in September of each year (beginning with 1987) promulgate the coinsurance amount which shall apply to extended care services furnished in the succeeding year. Such amount shall be equal to 20 percent of the national average per diem cost estimated under subparagraph (B) in that year. If the coinsurance amount determined under the preceding sentence is not a multiple of 50 cents, it shall be rounded to the nearest multiple of 50 cents (or, if it is a multiple of 25 cents but not a multiple of 50 cents, to the next higher multiple of 50 cents).

[(b)(1) The inpatient hospital deductible for 1987 shall be $520. The inpatient hospital deductible for any succeeding year shall be an amount equal to the inpatient hospital deductible for the pre-

ceding calendar year, changed by the applicable percentage increase (as defined in section 1886(b)(3)(B)) which is applied under section 1886(d)(3)(A) for discharges in the fiscal year that begins on October 1 of such preceding calendar year, and adjusted to reflect changes in real case mix (determined on the basis of the most recent case mix data available). Any amount determined under the preceding sentence which is not a multiple of $4 shall be rounded to the nearest multiple of $4 (or, if it is midway between two multiples of $4, to the next higher multiple of $4).

[(2) The Secretary shall promulgate the inpatient hospital deductible and all coinsurance amounts under this section between September 1 and September 15 of the year preceding the year to which they will apply.

[(3) The inpatient hospital deductible for a year shall apply to—

[(A) the deduction under the first sentence of subsection (a)(1) for the year in which the first day of inpatient hospital services occurs in a spell of illness, and

[(B) to the coinsurance amounts under subsection (a) for inpatient hospital services and post-hospital extended care services furnished in that year.]

(b)(1) The inpatient hospital deductible for 1987 shall be $520. The inpatient hospital deductible for any succeeding year shall be an amount equal to the inpatient hospital deductible for the preceding year increased by the applicable increase percentage determined under section 215(i) in the previous year. Any amount determined under the preceding sentence which is not a multiple of $1 shall be rounded to the nearest multiple of $1 (or, if it is a multiple of 50 cents but not a multiple of $1, to the next higher multiple of $1).

(2) Not later than November 15 of each year (beginning with 1987), the Secretary shall promulgate the inpatient hospital deductible under this subsection for the succeeding year.

(3) In this section, the term "period of continuous hospitalization" means, with respect to an individual, the period beginning on the first day the individual is furnished inpatient hospital services and ends on the individual's date of discharge (as established by the Secretary for purposes of section 1886) from the hospital (or, in the case of a transfer, hospitals) involved.

CONDITIONS OF AND LIMITATIONS ON PAYMENT FOR SERVICES

Requirement of Requests and Certifications

SEC. 1814. (a) Except as provided in subsections (d) and (g) and in section 1876, payment for services furnished an individual may be made only to providers of services which are eligible therefor under section 1866 and only if—

(1) * * *

(2) a physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations, except that the first of such recertifications shall be required in each case of inpatient hospital services not later than the 20th day of such period) that—

(A) * * *

(B) in the case of [post-hospital] extended care services, such services are or were required to be given because the individual needs or needed on a daily basis skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services, which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis[, for any of the conditions with respect to which he was receiving inpatient hospital services (or services which would constitute inpatient hospital services if the institution met the requirements of paragraphs (6) and (9) of section 1861(e)) prior to transfer to the skilled nursing facility or for a condition requiring such extended care services which arose after such transfer and while he was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services];

* * * * * * *

(6) with respect to inpatient hospital services or [post-hospital] extended care services furnished such individual during a continuous period, a finding has not been made (by the physician members of the committee or group, as described in section 1861(k)(4), including any finding made in the course of a sample or other review of admissions to the institution) pursuant to the system of utilization review that further inpatient hospital services or further [post-hospital] extended care services, as the case may be, are not medically necessary; except that, if such a finding has been made, payment may be made for such services furnished before the 4th day after the day on which the hospital or skilled nursing facility, as the case may be, received notice of such finding; and

(7) in the case of hospice care provided an individual—

(A)(i) in the first 90-day period—

(I) the individual's attending physician (as defined in section 1861(dd)(3)B)), and

(II) the medical director (or physician member of the interdisciplinary group described in section 1861(dd)(2)(B)) of the hospice program providing (or arranging for) the care,

each certify, not later than two days after hospice care is initiated, that the individual is terminally ill (as defined in section 1861(dd)(3)(A)), [and]

(ii) in a subsequent 90- or 30-day period, the medical director or physician described in clause (i)(II) recertifies at the beginning of the period that the individual is terminally ill [;], *and*

(iii) in a subsequent extension period, the medical director or physician described in clause (i)(II) recertifies at the beginning of the period that the individual is terminally ill;

* * * * * * *

Payments for Emergency Hospital Services

(d)(1) * * *

* * * * * * *

(3) The amounts payable under the preceding paragraph with respect to services described therein shall, subject to the provisions of section 1813, be equal to [60] *100* percent of the hospital's reasonable charges for routine services furnished in the accommodations occupied by the individual or in semiprivate accommodations (as defined in section 1861(v)(4)), whichever is less, plus [80] *100* percent of the hospital's reasonable charges for ancillary services. If separate charges for routine and ancillary services are not made by the hospital, reimbursement may be based on [two-thirds of] the hospital's reasonable charges for the services received but not to exceed the charges which would have been made if the patient had occupied semiprivate accommodations. For purposes of the preceding provisions of this paragraph, the term "routine services" shall mean the regular room, dietary, and nursing services, minor medical and surgical supplies and the use of equipment and facilities for which a separate charge is not customarily made; the term "ancillary services" shall mean those special services for which charges are customarily made in addition to routine services.

* * * * * * *

HOSPITAL INSURANCE BENEFITS FOR UNINSURED INDIVIDUALS NOT OTHERWISE ELIGIBLE

SEC. 1818. (a) * * *

* * * * * * *

[(d)(1) The monthly premium of each individual for each month in his coverage period before July 1974 shall be $33.

[(2) The Secretary shall, during the next to last calendar quarter of each year determine and promulgate the dollar amount (whether or not such dollar amount was applicable for premiums for any prior month) which shall be applicable for premiums for months occurring in the following calendar year. Such amount shall be equal to $33, multiplied by the ratio of (A) the inpatient hospital deductable for that following calendar year, as promulgated under section 1813(b)(2), to (B) such deductible promulgated for 1973. Any amount determined under the preceding sentence which is not a multiple of $1 shall be rounded to the nearest multiple of $1, or, if a multiple of 50 cents but not a multiple of $1, to the next higher multiple of $1.]

(d)(1) The Secretary shall, during September of each year (beginning with 1987), estimate the monthly actuarial rate for months in the succeeding year. Such actuarial rate shall be one-twelfth of the amount which the Secretary estimates (on an average, per capita basis) is equal to 100 percent of the benefits and administrative costs which will be payable from the Federal Hospital Insurance Trust Fund for services performed and related administrative costs incurred in the succeeding year with respect to individuals age 65 and over who will be entitled to benefits under this part during that entire year.

(2) The Secretary shall, during September of each year determine and promulgate the dollar amount which shall be applicable for premiums for months occurring in the following year. Such amount shall be equal to the monthly actuarial rate determined under paragraph (1) for that following year. Any amount determined under the preceding sentence which is not a multiple of $1 shall be rounded to the nearest multiple of $1 (or, if it is a multiple of 50 cents but not a multiple of $1, to the next higher multiple of $1).

(3) Whenever the Secretary promulgates the dollar amount which shall be applicable as the monthly premium under this section, he shall, at the time such promulgation is announced, issue a public statement setting forth the actuarial assumptions and bases employed by him in arriving at the amount of an adequate actuarial rate for individuals 65 and older as provided in paragraph (1).

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PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

* * * * * * *

SCOPE OF BENEFITS

SEC. 1832. (a) The benefits provided to an individual by the insurance program established by this part shall consist of—

(1) entitlement to have payment made to him or on his behalf (subject to the provisions of this part) for medical and other health services, except those described in subparagraphs (B) and (D) of paragraph (2); and

(2) entitlement to have payment made on his behalf (subject to the provisions of this part) for—

[(A) home health services;]

(A)(i) home health services, and (ii) subject to section 1839(h)(4), in-home care for a chronically dependent individual for up to 120 hours in any calendar year;

* * * * * * *

In the case of in-come care (described in paragraph (2)(A)(ii)) provided to a chronically dependent individual on any day, such care provided for 3 hours or less on the day shall be counted (for purposes of the limitation in such paragraph) as 3 hours of such care.

* * * * * * *

(b) For definitions of [“spell of illness”,] “medical and other health services”[,] and other terms used in this part, see section 1861.

PAYMENT OF BENEFITS

SEC. 1833. (a) Except as provided in section 1876, and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—

(1) in the case of services described in section 1832(a)(1)—80 percent of the reasonable charges for the services; except that (A) an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis may elect to be paid 80 percent of the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization in lieu of 80 percent of the reasonable charges for such services if the organization undertakes to charge such individuals no more than 20 percent of such reasonable cost plus any amounts payable by them as a result of subsection (b), (B) with respect to items and services described in section 1861(s)(10)(A), the amounts paid shall be 100 percent of the reasonable charges for such items and services, (C) with respect to expenses incurred for those physicians' services for which payment may be made under this part that are described in section 1862(a)(4), the amounts paid shall be subject to such limitations as may be prescribed by regulations, (D) with respect to clinical diagnostic laboratory tests for which payment is made under this part (i) on the basis of a fee schedule under subsection (h)(1), the amount paid shall be equal to 80 percent (or 100 percent, in the case of such tests for which payment is made on the basis of an assignment described in section 1842(b)(3)(B)(ii), under the procedure described in section 1870(f)(1), or for tests furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion) of the lesser of the amount determined under such fee schedule, the limitation amount for that test determined under subsection (h)(4)(B), or the amount of the charges billed for the tests, or (ii) on the basis of a negotiated rate established under subsection (h)(6), the amount paid shall be equal to 100 percent of such negotiated rate, (E) with respect to services furnished to individuals who have been determined to have end stage renal disease, the amounts paid shall be determined subject to the provisions of section 1881, (F) with respect to expenses incurred for services described in subsection (i)(3) under the conditions specified in such subsection, the amounts paid shall be the reasonable charge for such services, and (G) with respect to items and services (other than clinical diagnostic laboratory tests) furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion), the amounts paid shall be 100 percent of the reasonable charges for such items and services; [and] (H) with respect to services of a certified registered nurse anesthetist under section 1861(s)(11), the amounts paid shall be 80 percent of the lesser of the actual charge or the fee schedule for such services established by the Secretary in accordance with subsection (l), *and (I) with respect to expenses incurred for covered outpatient drugs, the amounts paid shall be the amounts determined under subsection (m)(2),*

(2) in the case of services described in section 1832(a)(2) (except those services described in subparagraphs *(A)(ii),* (D),

(E), and (F) of such section and unless otherwise specified in section 1881)—

* * * * * * *

(3) in the case of services described in subparagraphs [(D)] *(A)(ii), (D),* and (E) of section 1832(a)(2), the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v)(1)(A), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such services (other than for items and services described in section 1861(s)(10)(A) and for items and services furnished in connection with obtaining a second opinion required under section 1164(c)(2), or a third opinion, if the second opinion was in disagreement with the first opinion) exceed 80 percent of such costs; and

(4) in the case of facility services described in section 1832(a)(2)(F), and outpatient hospital facility services furnished in connection with surgical procedures specified by the Secretary pursuant to section 1833(i)(1)(A), the applicable amount as determined under paragraph (2) or (3) of subsection (i).

Payment for in-home care for chronically dependent individuals shall be paid on the basis of an hour of such care provided.

(b) Before applying subsection (a) with respect to expenses incurred by an individual during any calendar year, the total amount of the expenses incurred by such individual during such year (which would, except for this subsection, constitute incurred expenses from which benefits payable under subsection (a) are determinable) shall be reduced by a deductible of $75; except that (1) such total amount shall not include expenses incurred for items and services described in section 1861(s)(10)(A) *or for covered outpatient drugs,* (2) such deductible shall not apply with respect to home health services *or with respect to covered outpatient drugs,* (3) such deductible shall not apply with respect to clinical diagnostic laboratory tests for which payment is made under this part (A) under subsection (a)(1)(D)(i) or (a)(2)(D)(i) on the basis of an assignment described in section 1842(b)(3)(B)(ii), under the procedure described in section 1870(f)(1), or to a provider having an agreement under section 1866, or (B) on the basis of a negotiated rate determined under subsection (h)(6), and (4) such deductible shall not apply with respect to items and services furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion). The total amount of the expenses incurred by an individual as determined under the preceding sentence shall, after the reduction specified in such sentence, be further reduced by an amount equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during the calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood

(or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence.

(c)*(1)* Notwithstanding any other provision of this part, with respect to expenses incurred in any calendar year in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital at the time such expenses are incurred, there shall be considered as incurred expenses for purposes of subsections [(a) and (b)] *(a), (b), and (f)* only whichever of the following amounts is the smaller:

[(1) $312.50] *(A) the amount specified in paragraph (2) for that year* or

[(2)] *(B)* 62½ percent of such expenses.

(2) The amount specified in this paragraph for 1989 is $1,250. The amount specified in this paragraph for each succeeding year is the amount specified in this paragraph for the preceding year increased by the percentage increase in the MEI (as defined in section 1842(b)(4)(E)(ii)) for the year involved. If any amount determined under the previous sentence is not a multiple of $10, it shall be rounded to the nearest multiple of $10.

(3) In this subsection, the term "treatment" shall not be construed as including medical management visits.

* * * * * * *

(f)(1) Notwithstanding subsections (a) and (b), if an individual has incurred out-of-pocket part B expenses (as defined in paragraph (2)) in a calendar year (beginning with 1989) in an amount equal to the part B catastrophic limit (established under paragraph (3)) for the year, payment under this part with respect to any additional incurred expenses in the calendar year shall be made as if—

(A) the deduction described in the second sentence of subsection (b) (relating to blood) no longer applied, and

(B) "100 percent" and "0 percent" were substituted for "80 percent" and "20 percent", respectively, each place either appears in subsection (a), in section 1833(i)(2), in section 1835(b)(2), and in subsections (b)(2) and (b)(3) of section 1881.

(2) In this subsection, the term "out-of-pocket part B "expenses" means—

(A) the deductions established under subsection (b), and

(B) the difference between the payment amount provided under this part and the payment amount that would be provided if "100 percent" and "0 percent" were substituted for "80 percent" and "20 percent", respectively, each place either appears in subsection (a), in section 1833(i)(2), in section 1835(b)(2), and in subsections (b)(2) and (b)(3) of section 1881.

Such term also includes reasonable expenses (as defined by the Secretary) incurred for an annual colorectal examination for cancer and reasonable expenses (as defined by the Secretary) incurred for a mammogram, once every third year, for detection of breast cancer.

(3)(A) The part B catastrophic limit for 1989 is $1,043. The part B catastrophic limit for any succeeding year shall be an amount equal to the part B catastrophic limit for the preceding year increased by the applicable increase percentage determined under section 215(i) in the previous year. Any amount determined under the preceding sentence which is not a multiple of $1 shall be rounded to the nearest multiple of $1 (or, if it is a multiple of 50 cents but not a multiple of $1, to the next higher multiple of $1).

(B) Not later than November 15 of each year (beginning with 1988), the Secretary shall promulgate the part B catastrophic limit under this paragraph for the succeeding year.

(4) In applying paragraph (1) in the case of an organization receiving payment under clause (A) of subsection (a)(1) or under a reasonable cost reimbursement contract under section 1876—

(A) the Secretary shall provide for an appropriate adjustment in the payment amounts otherwise made to reflect, in the aggregate, the aggregate increase in payments that would otherwise be made with respect to enrollees in the organization if payments with respect to enrollees in the organization if payments were made other than under such clause or a contract or with respect to individuals furnished services through the facility if payments were to be made on an individual-by-individual basis, and

(B) the organization or facility shall provide assurances satisfactory to the Secretary that the organization or facility will not undertake to charge an individual during a year for services for which payment may be made under this part after the individual has incurred (whether through the organization, facility or otherwise) out-of-pocket part B expenses in the year in an amount equal to the part B catastrophic limit established under paragraph (3) for the year.

(5) In applying paragraphs (1) and (2), the amount specified in subsection (c)(2) is deemed to be $312.50.

(g) In the case of services described in the second sentence of section 1861(p), with respect to expenses incurred in any calendar year, no more than $500 shall be considered as incurred expenses for purposes of subsections [(a) and (b)] *(a), (b), and (f).* In the case of outpatient occupational therapy services which are described in the second sentence of section 1861(p) through the operation of section 1861(g), with respect to expenses incurred in any calendar year, no more than $500 shall be considered as incurred expenses for purposes of subsections [(a) and (b)] *(a), (b), and (f).*

(m)(1)(A) Before applying paragraph (2) with respect to expenses incurred by an individual for covered outpatient drugs dispensed in a calendar year, the individual must establish that the individual has incurred expenses for such drugs dispensed in the year (during a period in which the individual is entitled to benefits under this part) of the amount specified in subparagraph (C) for that year.

(B) If an individual applies to the Secretary to establish that the individual has met the requirement of subparagraph (A), the Secretary shall promptly notify the individual (and, if the application was submitted by or through a participating pharmacy, the pharmacy) as to whether or not the individual has met such requirement.

(C) The amount specified in this subparagraph for 1989 is $500. For each subsequent year, subject to subparagraph (D), the amount specified in this subparagraph is the amount specified in this subparagraph for the previous year increased by percentage change in the medical care component of the consumer price index for all urban consumers (U.S. city average, as published by the Bureau of Labor Statistics) during the 12-month period ending with August in that previous year. Any amount determined under the preceding sentence which is not a multiple of $1 shall be rounded to the next highest multiple of $1. In September of each year (beginning with 1989) the Secretary shall publish the deductible established under this subparagraph for the following year.

(D) If the monthly actuarial rate determined under section 1839(g)(1) for a year (after 1990) exceeds 120 percent of the monthly premium increase provided under section 1839(g)(2) for months in the preceding year, the Secretary shall increase the amount otherwise specified under subparagraph (C) for that year (and only for that year) by such an amount as will assure that—

(i) the aggregate amount of the monthly premium increase provided under section 1839(g) for the year for all enrollees,

is equal to—

(ii) the total of the benefits and administrative costs which the Secretary estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for covered outpatient drugs dispensed and related administrative costs incurred in such year for all such enrollees.

(2) Subject to the deductible established under paragraph (1)(A), the amount payable under this part with respect to a covered outpatient drug is equal to the actual charge for the drug, or, if lower, the applicable payment limit described in paragraph (3).

(3)(A) In the case of a covered outpatient drug that either is not a multiple source drug (as defined in paragraph (6)(A)) or is a multiple source drug and has a restrictive prescription (as defined in paragraph (6)(B)), the payment limit for the drug under this paragraph is the sum of—

(i) the product of (I) the number of tablets (or other dosage units) dispensed and (II) the average per tablet or unit wholesale price for the drug (as determined under paragraph (4)), and

(ii) an administrative allowance of $4.50.

(B) In the case of a covered outpatient drug that is a multiple source drug but does not have a restrictive prescription, the payment limit for the drug under this paragraph is the sum of—

(i) the product of (I) the number of tablets (or other dosage units) dispensed and (II) the amount specified under subparagraph (C), and

(ii) an administrative allowance of $4.50.

(C) The amount specified under this subparagraph with respect to a multiple source drug dispensed in a year is 50 percent of the highest of the average per tablet or unit wholesale price for any drug product described in paragraph (5)(A) with respect to that drug, as in effect as of January 1, 1987, increased, for each year after 1987 and up to the year involved, by the percentage increase in the consumer price index for all urban consumers (all items, U.S. city aver-

age, as published by the Bureau of Labor Statistics) for the 12-month period ending in August of the previous year.

(D) The Secretary, before each payment calculation period (as defined in paragraph (5)(C)), shall provide for the distribution to participating pharmacies (as defined in section 1842(i)) and to groups representing or assisting individuals entitled to benefits under this part, of information on the payment limits established under this paragraph.

(4)(A) For purposes of this subsection, the Secretary shall determine, with respect to dispensing of each covered outpatient drug in each payment calculation period, the average per tablet or unit wholesale price for the drug. Such average shall be based on the average wholesale price (or when available, the manufacturer's direct price) for purchases in reasonable quantities. Such determination shall be made for each payment calculation period based on whole or direct prices for the first day of the third month before the beginning of the period. The Secretary shall make such determination, and calculate the payment limits under paragraph (3) on a national basis; except that the Secretary may make such determination, and calculate such payment limits, on a regional basis to take account of limitations on the availability of drug products and variations among regions in the average wholesale or direct price for a drug product.

(B) In order to prevent abusive practices in the prescribing or dispensing of covered outpatient drugs, the Secretary may provide that payment for covered outpatient drugs many not be made they are prescribed or dispensed with excessive frequency or in excessive quantities.

(5) In this subsection:

(A) The term "multiple source drug" means, with respect to a payment calculation period, a covered outpatient drug for which there are 2 or more drug products which—

(i) are considered to be therapeutically equivalent (under the Food and Drug Administration's most recent publication of "Approved Drug Products with Therapeutic Equivalence Evaluations", available on the first day of the third month before the beginning of the period), and

(ii) are sold or marketed during the period.

For purposes of clause (ii), a drug is considered to be sold or marketed during a period if it is listed in the publications referred to in clause (i) for the third month before the beginning of the period, unless the Secretary determines that such sale or marketing is not actually taking place.

(B) A drug has a "restrictive prescription" only if the prescription for the drug indicates, in the handwriting of the physician or other person prescribing the drug and with an appropriate phrase (such as "brand medically necessary") recognized by the Secretary, that the particular drug must be dispensed.

(C) The term "payment calulation period" means the 6-month period beginning with January of each year (after 1988) and the 6-month period beginning with July of each year (after 1988).

PROCEDURE FOR PAYMENT OF CLAIMS OF PROVIDERS OF SERVICES

SEC. 1835. (a) Except as provided in subsections (b), (c), and (e), payment for services described in section 1832(a)(2) furnished an individual may be made only to providers of services which are eligible therefor under section 1866(a), and only if—

(1) * * *

(2) a physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations) that—

(A) * * *

* * * * * * *

(D) in the case of outpatient speech pathology services, (i) such services are or were required because the individual needed speech pathology services, (ii) a plan for furnishing such services has been established by a physician or by the speech pathologist providing such services and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician; [and]

(E) in the case of comprehensive outpatient rehabilitation facility services, (i) such services are or were required because the individual needed skilled rehabilitation services, (ii) a plan for furnishing such services has been established and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician[.]*; and*

(F) in the case of in-home care provided to a chronically dependent individual during a 12-month period, the individual was a chronically dependent individual during the 3-month period immediately preceding the beginning of the 12-month period.

* * * * * * *

AMOUNTS OF PREMIUMS

SEC. 1839. (a)(1) The Secretary shall, during September of 1983 and of each year thereafter, determine the monthly actuarial rate for enrollees age 65 and over which shall be applicable for the succeeding calendar year. Such actuarial rate shall be the amount the Secretary estimates to be necessary so that the aggregate amount for such calendar year with respect to those enrollees age 65 and older will equal one-half of the total of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for services performed and related administrative costs incurred in such calendar year with respect to such enrollees *(other than costs relating to covered outpatient drugs, costs relating to in-home care, as defined in section 1861(ff)(1), costs relating to influenza vaccine and its administration, and costs attributable to section 1812(f)).* In calculating the monthly actuarial rate, the Secretary shall include an appropriate amount for a contingency margin.

(2) The monthly premium of each individual enrolled under this part for each month after December 1983 shall, except as provided in subsections (b) [and (e)], *(e), (g), (h), and (i),* be the amount determined under paragraph (e).

(3) The Secretary shall, during September of 1983 and of each year thereafter, determine and promulgate the monthly premium applicable for individuals enrolled under this part for the succeeding calendar year. The monthly premium shall (except as otherwise provided in [subsection (e)] *subsections (e), (g), (h), and (i))* be equal to the smaller of—

(A) the monthly actuarial rate for enrollees age 65 and over, determined according to paragraph (1) of this subsection, for that calendar year, or

(B) the monthly premium rate most recently promulgated by the Secretary under this paragraph, increased by a percentage determined as follows: The Secretary shall ascertain the primary insurance amount computed under section 215(a)(1), based upon average indexed monthly earnings of $900, that applied to individuals who became eligible for and entitled to old-age insurance benefits on November 1 of the year before the year of the promulgation. He shall increase the monthly premium rate by the same percentage by which that primary insurance amount is increased when, by reason of the law in effect at the time the promulgation is made, it is so computed to apply to those individuals for the following November 1.

Whenever the Secretary promulgates the dollar amount which shall be applicable as the monthly premium for any period, he shall, at the time such promulgation is announced, issue a public statement setting forth the actuarial assumptions and bases employed by him in arriving at the amount of an adequate actuarial rate for enrollees age 65 and older as provided in paragraph (1) and the deviation of the dollar amounts specified in this paragraph.

(4) The Secretary shall also, during September of 1983 and of each year thereafter, determine the monthly actuarial rate for disabled enrollees under age 65 which shall be applicable for the succeeding calendar year. Such actuarial rate shall be the amount the Secretary estimates to be necessary so that the aggregate amount for such calendar year with respect to disabled enrollees under age 65 which will equal one-half of the total of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for services performed and related administrative costs incurred in such calendar year with respect to such enrollees *(other than costs relating to covered outpatient drugs, costs relating to in-home care, as defined in section 1861(ff)(1), costs relating to influenza vaccine and its administration, and costs attributable to section 1812(f)).* In calculating the monthly actuarial rate under this paragraph, the Secretary shall include an appropriate amount for a contingency margin.

(b) In the case of an individual whose coverage period began pursuant to an enrollment after his initial enrollment period (determined pursuant to subsection (c) or (d) of section 1837), the monthly premium [determined under subsection (a) or (e)] *otherwise determined under this section (without regard to subsection (f))* shall be increased by 10 percent of the monthly premium so determined for

each full 12 months (in the same continuous period of eligibility) in which he could have been but was not enrolled. For purposes of the preceding sentence, there shall be taken into account (1) the months which elapsed between the close of his initial enrollment period and the close of the enrollment period in which he enrolled, plus (in the case of an individual who reenrolls) (2) the months which elapsed between the date of termination of a previous coverage period and the close of the enrollment period in which he reenrolled, but there shall not be taken into account months during which the individual has attained the age of 65 and for which the individual can demonstrate that the individual was enrolled in a group health plan described in section 1862(b)(3)(A)(iv) by reason of the individual's (or the individual's spouse's) current employment or months during which the individual has not attained the age of 65 and for which the individual can demonstrate that the individual was enrolled in a large group health plan as an active individual (as those terms are defined in section 1862(b)(4)(B)). Any increase in an individual's monthly premium under the first sentence of this subsection with respect to a particular continuous period of eligibility shall not be applicable with respect to any other continuous period of eligibility which such individual may have.

* * * * * * *

(e)(1) * * *

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(3)(A) Notwithstanding the provisions of subsection (a), but subject to the provisions of subsections (g), (h), and (i) the monthly premium for each individual enrolled under this part for each month—

(i) in 1990 shall be $1.00 greater than the amount otherwise determined under subsection (a), and

(ii) in 1991 shall be 40 cents greater than the amount otherwise determined under subsection (a).

Any increases in premium amounts taking effect under this paragraph for months in a year shall be taken into account for purposes of determining increases in each subsequent year under subsection (a)(3).

(B) Subparagraph (A) does not apply to premiums determined under paragraph (4) or (5).

(4)(A) Notwithstanding the provisions of subsection (a), but subject to subsections (g), (h), and (i), in the case of an individual who is a resident of a commonwealth or territory during a month—

(i) in 1988 or 1989, the monthly premium otherwise determined for the individual under paragraph (1) or subsection (a)(3), respectively, shall be increased by the amount described in subparagraph (B) for that month; or

(ii) in a subsequent year, the monthly premium which shall apply shall be the amount described in subparagraph (C) for that month.

(B) The amount described in this subparagraph for a month in 1988 or 1989 for an individual residing in a particular commonwealth or territory is $\frac{1}{12}$th of the product of—

(i) the average, per capita additional benefits (and related administrative costs), as determined by the Secretary during September of the previous year, that will be payable under this title during the year by reason of the amendments made by the Medicare Catastrophic Protection Act of 1987 (other than sections 202, 203, and 206 thereof); and

(ii) the ratio (determined by the Secretary for that commonwealth or territory during September 1987) of—

(I) the per capita actuarial value of the benefits under this title for residents of the commonwealth or territory who are entitled to benefits under both part A and this part, to

(II) the per capita actuarial value of the benefits under this title for residents of the United States who are entitled to benefits under both part A and this part.

(C) The amount described in this subpargraph for a month in—

(i) 1990, is the sum of—

(I) the monthly premium established under subsection (a)(3) for months in 1989, and

(II) the amount described in subparagraph (B) for months in 1989,

increased by the premium percentage increase (as defined in subparagraph (E)()ii)) for 1990; or

(ii) a succeeding year is the amount described in this subparagraph for months in the previous year increased by the premium increase percentage for that succeeding year.

(D) If any amount determined under the previous provisions of this subparagraph is not a multiple of 10 cents, the Secretary shall round the amount to the nearest multiple of 10 cents.

(E) In this paragraph:

(i) The term "commonwealth or territory" means Puerto Rico, the Virgin Islands, Guam, American Samoa, or the Northern Mariana Islands.

(ii) The term "percentage premium increase", for a year, means the percentage determined under subsection (a)(3)(B) in the previous year.

(5)(A) Notwithstanding the provisions of subsection (a), but subject to subsections (g), (h), and (i), in the case of a part B only individual (as defined in subparagraph (E)) during a month—

(i) in 1989, the monthly premium otherwise determined for the individual under subsection (a)(3) shall be increased by the amount described in subparagraph (B); or

(ii) in a subsequent year, the monthly premium which shall apply shall be the amount described in subparagraph (C) for that month.

(B) The amount described in this subparagraph is $\frac{1}{12}$th of the average, per capita additional benefits (and related administrative costs) that the Secretary estimates (during September of 1988) will be payable under this part during 1989 by reason of the amendments made by the Medicare Catastrophic Protection Act of 1987 (other than sections 202, 203, and 206 thereof).

(C) The amount described in this subparagraph for a month—

(i) in 1990, is the sum of—

(I) the monthly premium established under subsection (a)(3) for months in 1989, and

(II) the amount described in subparagraph (B),

increased by the premium percentage increase (as defined in paragraph (4)(E)(ii)) for 1990; or

(ii) in a succeeding year is the amount described in this subparagraph for months in the previous year increased by the premium increase percentage (as so defined) for that succeeding year.

(D) If any amount determined under the previous provisions of this paragraph is not a multiple of 10 cents, the Secretary shall round the amount to the nearest multiple of 10 cents.

(E) In this paragraph the term "part B only individual" means, with respect to a premium for a month, an individual who—

(i) is not a resident of a commonwealth or territory (as defined in paragraph (4)(E)(i)) during the month,

(ii) is entitled to benefits under this part, and

(iii) is not entitled to (or, on application without payment of an additional premium, would not be entitled to) benefits under part A.

* * * * * * *

(g)(1)(A) The Secretary shall, during September of 1987 and of each year thereafter, determine a monthly actuarial rate for covered outpatient drugs which shall be applicable for the succeeding calendar year.

(B) Subject to subparagraph (C), such actuarial rate shall be the amount the Secretary estimates to be necessary so that the aggregate amount for such calendar year with respect to enrollees will equal 100 percent of the total of the benefits and administration costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for covered outpatient drugs dispensed and related administrative costs incurred in such calendar year with respect to such enrollees.

(C) In establishing the monthly actuarial rate under this paragraph for each year (after 1990), the Secretary shall take into account any net surplus or deficit of the aggregate amount of the monthly premium increases provided under paragraph (2) for previous years for all enrollees over the total of the benefits and administrative costs which the Secretary determines were paid from the Federal Supplementary Medical Insurance Trust Fund for covered outpatient drugs dispensed and related administrative costs incurred in such previous years for all such enrollees.

(2) Subject to paragraph (3), notwithstanding any other provisions of this section (except as provided in subsections (b) and (f)), the monthly premium of each individual enrolled under this part for each month in a year after December 1987 shall be increased by the monthly actuarial rate determined according to paragraph (1) for that year; except that if the increase determined under this paragraph is not a multiple of 10 cents, it shall be rounded to the nearest multiple of 10 cents.

(3) The increase in monthly premium under paragraph (2) for each month in—

(A) 1988 may not exceed $0.30,

(B) 1989 may not exceed $3.20,

(C) 1990 may not exceed $4.90, and

(D) a subsequent year may not exceed 120 percent of the monthly premium increase under paragraph (2) for months in the preceding year.

(h)(1)(A) The Secretary shall, during September of 1988 and of each year thereafter, determine a monthly actuarial rate for in-home care (as defined in section 1861(ff)(1)) which shall be applicable for the succeeding calendar year.

(B) Such actuarial rate shall be the amount the Secretary estimates to be necessary so that the aggregate amount for such calendar year with respect to enrollees will equal 100 percent of the total of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for in-home care provided and related administrative costs incurred in such calendar year with respect to such enrollees.

(C) In establishing the monthly actuarial rate under this paragraph for each year (after 1990), the Secretary shall take into account any net surplus or deficit of the aggregate amount of the monthly premium increases provided under paragraph (2) for previous years for all enrollees over the total of the benefits and administrative costs which the Secretary determies were paid from the Federal Supplementary Medical Insurance Trust Fund for in-home care provided and related administrative costs incurred in such previous years for all such enrollees.

(2) Subject to paragraph (3), notwithstanding any other provision of this section (expect as provided in subsections (b) and (f)), the monthly premium of each individual enrolled under this part for each month in a year after December 1988 shall be increased by the monthly actuarial rate determined according to paragraph (1) for that year; except that if the increase determined under this paragraph is not a multiple of 10 cents, it shall be rounded to the nearest multiple of 10 cents.

(3) The increase in monthly premium under paragraph (2) for each month in—

(A) 1989 may not exceed $0.40,

(B) 1990 may not exceed $0.70, and

(C) a subsequent year may not exceed 120 percent of the monthly premium increase provided under paragraph (2) for months in the preceding year.

(4) If the monthly actuarial rate determined under paragraph (1) for a year (after 1990) exceeds 120 percent of the monthly premium increase provided under paragraph (2) for months in the preceding year, the Secretary shall decrease the maximum number of hours of in-home care under section 1832(a)(2)(A)(ii) in that year (and only in that year) by such an amount as will assure that—

(A) the aggregate amount of the monthly premium increase provided under this subsection for the year for all enrollees,

is equal to—

(B) the total of the benefits and administrative costs which the Secretary estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for in-home care provided and related administrative costs incurred in such year for all such enrollees.

(i)(1) The Secretary shall, during September of 1988 and for each year thereafter, determine a monthly actuarial rate for influenza vaccine and its administration which shall be applicable for the succeeding calendar year. Such actuarial rate shall be the amount the Secretary estimates to be necessary so that the aggregate amount for such calendar year with respect to enrollees will equal 100 percent of the total of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for influenza vaccine and related administrative costs incurred in such calendar year with respect to such enrollees.

(2) Notwithstanding any other provision of this section (except as provided in subsections (b) and (f)), the monthly premium of each individual enrolled under this part for each month in a year after December 1988 shall be increased by the monthly actuarial rate determined according to paragraph (1) for that year; except that if the increase determined under this paragraph is not a multiple of 10 cents, it shall be rounded to the nearest multiple of 10 cents.

* * * * * * *

USE OF CARRIERS FOR ADMINISTRATION OF BENEFITS

SEC. 1842. (a) * * *

(b)(1) Contracts with carriers under subsection (a) may be entered into without regard to section 3709 of the Revised Statutes or any other provision of law requiring competitive bidding.

(2) No such contract shall be entered into with any carrier unless the Secretary finds that such carrier will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as he finds pertinent. The Secretary shall publish in the Federal Register standards and criteria for the efficient and effective performance of contract obligations under this section, and opportunity shall be provided for public comment prior to implementation. *With respect to carrying out functions relating to payment for the Secretary may enter into contracts with carriers under this section to perform such functions on a regional basis.*

(3) Each such contract shall provide that the carrier—

(A) * * *

* * * * * * *

(G) will provide to each nonparticipating physician, at the beginning of each year, a list of the physician's maximum allowable actual charges (established under subsection (j)(1)(C)) for the year for the physicians' services mostly commonly furnished by that physician; [and]

(H) if it makes determinations or payments with respect to physicians' services, will implement—

(i) programs to recruit and retain physicians as participating physicians in the area served by the carrier, including educational and outreach activities and the use of professional relations personnel to handle billing and other problems relating to payment of claims of participating physicians; and

(ii) programs to familiarize beneficiaries with the participating physician program and to assist such beneficiaries in locating participating physicians;

(I) if it makes determinations or payments with respect to items and services furnished by a physician for which payment is made pursuant to section 1833(f) but not on an assignment-related basis, provide to the physician a notice that—

(i) states that the individual provided the service has reached the part B catastrophic limit on out-of-pocket expenses for the year, and

(ii) encourages the physician not to charge the individual amounts in excess of the reasonable charge recognized under this section and to accept payment on an assignment-related basis for physicians' services furnished the individual during the remainder of the year; and

(J) if it makes determinations or payments with respect to covered outpatient drugs, will—

(i) offer, at the option of participating pharmacies, to receive requests for payments for such drugs through electronic communications, and

(ii) respond to requests by paticipating pharmacies as to whether or not an individual has met the deductible requirement of section 1833(m)(1)(A) for a year;

* * * * * *

(c)(1) * * *

(2)(A) * * *

(B) In this paragraph:

(i) The term "clean claim" means a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this part.

(ii) The term "applicable number of calendar days" means—

(I) * * *

* * * * * * *

(III) with respect to claims received in the 12-month period beginning October 1, 1988, 25 calendar days (or 18 calendar days with respect to claims submitted by participating physicians *or by participating pharmacies*), and

(IV) with respect to claims received in the 12-month period beginning October 1, 1989, and claims received in any succeeding 12-month period, 24 calendar days (or 17 calendar days with respect to claims submitted by participating physicians *or by participating pharmacies*).

* * * * * * *

(h)(1) Any physician or supplier may voluntarily enter into an agreement with the Secretary to become a participating physician or supplier. For purposes of this section, the term "participating physician or supplier" means a physician or supplier (excluding any provider of services) who, before the beginning of any year beginning with 1984, enters into an agreement with the Secretary which provides that such physician or supplier will accept payment

under this part on an assignment-related basis for all items and services furnished to individuals enrolled under this part during such year *and, with respect to a supplier of covered outpatient drugs, is a participating pharmacy (as defined in subsection (i)(1))*. In the case of a newly licensed physician or a physician who begins a practice in a new area, or in the case of a new supplier who begins a new business, or in such similar cases as the Secretary may specify, such physician or supplier may enter into such an agreement after the beginning of a year, for items and services furnished during the remainder of the year.

* * * * * * *

(6) The Secretary shall provide that the directories shall be available for purchase by the public. The Secretary shall provide that each appropriate area directory is sent to each participating physician located in that area *and to each individual enrolled under this part and residing in that area* and that an appropriate number of copies of each such directory is sent to hospitals located in the area. Such copies shall be sent free of charge.

* * * * * * *

(i)(1) For purposes of this section, the term "participating pharmacy" means an entity which is authorized under a State law to dispense covered outpatient drugs and which has entered into an agreement with the Secretary, providing at least the following:

(A) The entity agrees—

(i) not to refuse to dispense covered outpatient drugs items stocked by the entity to any individual entitled to benefits under this part (in this section referred to as "medicare beneficiaries"), and

(ii) not to change medicare beneficiaries more for such drugs than the amount it charges to the general public.

(B) The entity agrees to keep patient records (including records on expenses incurred by medicare beneficiaries) for all covered outpatient drugs dispensed to all such beneficiaries.

(C) The entity agrees—

(i) to assist medicare beneficiaries in determining whether or not their expenses (for covered outpatient drugs dispensed in a year) have exceeded the deductible under section 1833(m)(1)(A), including providing the documentation necessary to establish this, and

(ii) on behalf and on the request of such a beneficiary, to submit to the carrier such documentation as the Secretary requires.

(D) The entity agrees, upon request of a medicare beneficiary, to provide a copy of the records maintained under subparagraph (B) to another participating pharmacy or to a carrier under this section.

(E) The entity agrees—

(i) to offer to counsel, or to offer to provide information to, each medicare beneficiary on the appropriate use of a drug to be dispensed and whether there are potential interactions between the drug and other drugs dispensed to the beneficiary; and

(ii) to advise the beneficiary on the availability (consistent with State laws respecting substitution of drugs) of therapeutically equivalent covered outpatient drugs.

(2) The Secretary shall provide to each participating pharmacy—

(A) a distinctive emblem (suitable for display to the public) indicating that the pharmacy is a participating pharmacy, and

(B) before the beginning of each payment calculation period, information on the payment limits established under paragraphs (3) and (4) of section 1833(m).

(3) The Secretary shall provide for periodic audits of participating pharmacies to assure that they do not impose charges in excess of the amounts permitted under paragraph (1)(A)(ii).

(4) Notwithstanding subsection (b)(3)(B), payment for covered outpatient drugs may be made on the basis of an assignment described in clause (ii) of that subsection only to a participating pharmacy.

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STATE AGREEMENTS FOR COVERAGE OF ELIGIBLE INDIVIDUALS WHO ARE RECEIVING MONEY PAYMENTS UNDER PUBLIC ASSISTANCE PROGRAMS (OR ARE ELIGIBLE FOR MEDICAL ASSISTANCE)

SEC. 1843. (a) The Secretary shall, at the request of a State made before January 1, 1970, or during 1981 *or after 1987,* enter into an agreement with such State pursuant to which all eligible individuals in either of the coverage groups described in subsection (b) (as specified in the agreement) will be enrolled under the program established by this part.

* * * * * * *

(g)(1) The Secretary shall, at the request of a State made before January 1, 1970, or during 1981 *or after 1987,* enter into a modification of an agreement entered into with such State pursuant to subsection (a) under which the second sentence of subsection (b) shall not apply with respect to such agreement.

* * * * * * *

(h)(1) The Secretary shall, at the request of a State made before January 1, 1970, or during 1981 *or after 1987,* enter into a modification of an agreement entered into with such State pursuant to subsection (a) under which the coverage group described in subsection (b) and specified in such agreement is broadened to include individuals who are eligible to receive medical assistance under the plan of such State approved under title XIX.

* * * * * * *

APPROPRIATIONS TO COVER GOVRNMENT CONTRIBUTIONS AND CONTINGENCY RESERVE

SEC. 1844. (a) There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Federal Supplementary Medical Insurance Trust Fund—

(1) * * *

(2) such sums as the Secretary deems necessary to place the Trust Fund, at the end of any fiscal year occurring after June

30, 1967, in the same position in which it would have been at the end of such fiscal year if (A) a Government contribution representing the excess of the premiums deposited in the Trust Fund during the fiscal year ending June 30, 1967, over the Government contribution actually appropriated to the Trust Fund during such fiscal year had been appropriated to it on June 30, 1967, and (B) the Government contribution for premiums deposited in the Trust Fund after June 30, 1967, had been appropriated to it when such premiums were deposited.

In computing the amount of aggregate premiums and premiums per enrollee under paragraph (1), there shall not be taken into account premiums attributable to section 1839(g) such premiums shall be computed as though the clause "(other than costs attributable to section 1812(f))" was deleted from paragraphs (1) and (4) of section 1839(a).

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Part C—Miscellaneous Provisions

definitions of services, institutions, etc.

Sec. 1861. For purposes of this title—

[Spell of Illness

[(a) The term "spell of illness" with respect to any individual means a period of consecutive days—

[(1) beginning with the first day (not included in a previous spell of illness) (A) on which such individual is furnished inpatient hospital services or extended care services, and (B) which occurs in a month for which he is entitled to benefits under part A, and

[(2) ending with the close of the first period of 60 consecutive days thereafter on each of which he is neither an inpatient of a hospital nor an inpatient of a skilled nursing facility.]

* * * * * * *

Hospital

(e) The term "hospital" (except for purposes of sections 1814(d), 1814(f), and 1835(b), subsection (a)(2) of this section, *and* paragraph (7) of this subsection[, and subsection (i) of this section]) means an institution which—

(1) is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

* * * * * * *

[For purposes of subsection (a)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection.] For purposes of sections 1814(d) and 1835(b) (including determination of whether an individual received inpatient hospital serv-

ices or diagnostic services for purposes of such sections), [section 1814(f)(2), and subsection (i) of this section] *and section 1814(f)(2),* such term includes any institution which (i) meets the requirements of paragraphs (5) and (7) of this subsection, (ii) is not primarily engaged in providing the services described in section 1861(j)(1)(A) and (iii) is primarily engaged in providing, by or under the supervision of individuals referred to in paragraph (1) of section 1861(r), to inpatients diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. For purposes of section 1814(f)(1), such term includes an institution which (i) is a hospital for purposes of sections 1814(d), 1814(f)(2), and 1835(b) and (ii) is accredited by the Joint Commission on Accreditation of Hospitals, or is accredited by or approved by a program of the country in which such institution is located if the Secretary finds the accreditation or comparable approval standards of such program to be essentially equivalent to those of the Joint Commission on Accreditation of Hospitals. Notwithstanding the preceding provisions of this subsection, such term shall not[, except for purposes of subsection (a)(2),] include any institution which is primarily for the care and treatment of mental diseases unless it is a psychiatric hospital (as defined in subsection (f)). The term "hospital" also includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, but only with respect to items and services ordinarily furnished by such institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations. For provisions deeming certain requirements of this subsection to be met in the case of accredited institutions, see section 1865. The term "hospital" also includes a facility of fifty beds or less which is located in an area determined by the Secretary to meet the definition relating to a rural area described in subparagraph (A) of paragraph (5) of this subsection and which meets the other requirements of this subsection, except that—

(A) * * *

* * * * * * *

[Post-Hospital Extended Care Services

[(i) The term "post-hospital extended care services" means extended care services furnished an individual after transfer from a hospital in which he was an inpatient for not less than 3 consecutive days before his discharge from the hospital in connection with such transfer. For purposes of the preceding sentence, items and services shall be deemed to have been furnished to an individual after transfer from a hospital, and he shall be deemed to have been an inpatient in the hospital immediately before transfer therefrom, if he is admitted to the skilled nursing facility (A) within 30 days after discharge from such hospital, or (B) within such time as it would be medically appropriate to begin an active course of treat-

ment, in the case of an individual whose condition is such that skilled nursing facility care would not be medically appropriate within 30 days after discharge from a hospital; and an individual shall be deemed not to have been discharged from a skilled nursing facility if, within 30 days after discharge therefrom, he is admitted to such facility or any other skilled nursing facility.]

Skilled Nursing Facility

(j) The term "skilled nursing facility" means (except for purposes of subsection (a)(2)) an institution (or a distinct part of an institution) which has in effect a transfer agreement (meeting the requirements of subsection (l)) with one or more hospitals having agreements in effect under section 1866 and which—

(1) is primarily engaged in providing to inpatients (A) skilled nursing care and related services for patients who require medical or nursing care, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

* * * * * * *

except that such term shall not [(other than for purposes of subsection (a)(2))] include any institution which is primarily for the care and treatment of mental diseases. [For purposes of subsection (a)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection.] The term "skilled nursing facility" also includes an institution described in paragraph (1) of subsection (y), to the extent and subject to the limitations provided in such subsection. To the extent that paragraph (6) of this subsection may be deemed to require that any skilled nursing facility engage the services of a registered professional nurse for more than 40 hours a week, the Secretary is authorized to waive such requirement if he finds that—

(A) such facility is located in a rural area and the supply of skilled nursing facility services in such area is not sufficient to meet the needs of individuals residing therein,

(B) such facility has one full-time registered professional nurse who is regularly on duty at such facility 40 hours a week, and

(C) such facility (i) has only patients whose physicians have indicated (through physicians' orders or admission notes) that each such patient does not require the services of a registered nurse or a physician for a 48-hour period, or (ii) has made arrangements for a registered professional nurse or a physician to spend such time at such facility as may be indicated as necessary by the physician to provide necessary skilled nursing services on days when the regular full-time registered professional nurse is not on duty.

* * * * * * *

Home Health Services

(m) The term "home health services" means the following items and services furnished to an individual, who is under the care of a physician, by a home health agency or by others under arrangements with them made by such agency, under a plan (for furnish-

ing such items and services to such individual) established and periodicially reviewed by a physician, which items and services are, except as provided in paragraph (7), provided on a visiting basis in a place of residence used as such individual's home—

(1) part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

(2) physical, occupational, or speech therapy;

(3) medical social services under the direction of a physician;

(4) to the extent permitted in regulations, part-time or intermittent services of a home health aide who has successfully completed a training program approved by the Secretary;

(5) medical supplies (other than drugs and biologicals) and durable medical equipment, while under such a plan;

(6) in the case of a home health agency which is affiliated or under common control with a hospital, medical services provided by an intern or resident-in-training of such hospital, under a teaching program of such hospital approved as provided in the last sentence of subsection (b); and

(7) any of the foregoing items and services which are provided on an outpatient basis, under arrangements made by the home health agency, at a hospital or skilled nursing facility, or at a rehabilitation center which meets such standards as may be prescribed in regulations, and—

(A) the furnishing of which involves the use of equipment of such a nature that the items and services cannot readily be made available to the individual in such place of residence, or

(B) which are furnished at such facility while he is there to receive any such item or service described in clause (A),

but not including transportation of the individual in connection with any such item or service;

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital. *For purposes of paragraphs (1) and (4) and sections 1814(a)(2)(C) and 1835(a)(2)(A), nursing care and home health aide services shall be considered to be provided or needed on an "intermittent" basis if they are provided or needed less than 7 days each week and, in the case they are provided or needed for 7 days each week, if they are provided or needed for an initial period of up to 35 consecutive days, and for a subsequent period based on a physician certification of exceptional circumstances requiring such services on such a basis.*

* * * * * * *

Medical and Other Health Services

(s) The term "medical and other health services" means any of the following items or services:

(1) physicians' services;

(2)(A) * * *

* * * * * * *

[(J) immunosuppressive drugs furnished, to an individual who receives an organ transplant for which payment is made

under this title, within 1 year after the date of the transplant procedure; and]

(J) covered outpatient drugs (as defined in subsection (t)(2)); and

* * * * * * *

(10)(A) pneumococcal vaccine and its administration *and influenza vaccine and its administration;* and

(B) hepatitis B vaccine and its administration, furnished to an individual who is at high or intermediate risk of contracting hepatitis B (as determined by the Secretary under regulations); and

* * * * * * *

Drugs and Biologicals

(t)*(1)* The term "drugs" and the term "biologicals", except for purposes of [subsection (m)(5)] *subsections (m)(5) and (s)(2)(J) and paragraph (2)* of this section, include only such drugs and biologicals, respectively, as are included (or approved for inclusion) in the United States Pharmacopoeia, the National Formulary, or the United States Homeopathic Pharmacopoeia, or in New Drugs or Accepted Dental Remedies (except for any drugs and biologicals unfavorably evaluated therein), or as are approved by the pharmacy and drug therapeutics committee (or equivalent committee) of the medical staff of the hospital furnishing such drugs and biologicals for use in such hospital.

(2) The term "covered outpatient drug" means—

(A) a drug which—

(i) is approved for safety and effectiveness as a prescription drug under section 505 or 507 of the Federal Food, Drug, and Cosmetic Act, or

(ii) in the case of a drug which is biological product, is licensed under section 351 of the Public Health Service Act, and

(B) insulin certified under section 506 of the Federal Food, Drug, and Cosmetic Act;

but does not include any drug or insulin provided to an inpatient as part of inpatient hospital services (described in subsection (b)(2)), as part of extended care services (described in subsection (h)(5)), or as an incident to physicians' services under subparagraph (A) or (B) of subsection (s)(2).

* * * * * * *

Reasonable Cost

(v)(1)(A) * * *

* * * * * * *

(G)(i) In any case in which a hospital provides inpatient services to an individual that would constitute [post-hospital] extended care services if provided by a skilled nursing facility and a quality control and peer review organization (or, in the absence of such a qualified organization, the Secretary or such agent as the Secretary

may designate) determines that inpatient hospital services for the individual are not medically necessary but [post-hospital] extended care services for the individual are medically necessary and such extended care services are not otherwise available to the individual (as determined in accordance with criteria established by the Secretary) at the time of such determination, payment for such services provided to the individual shall continue to be made under this title at the payment rate described in clause (ii) during the period in which—

(I) such [post-hospital] extended care services for the individual are medically necessary and not otherwise available to the individual (as so determined),

(II) inpatient hospital services for the individual are not medically necessary, and

(III) the individual is entitled to have payment made for [post-hospital] extended care services under this title,

except that if the Secretary determines that there is not an excess of hospital beds in such hospital and (subject to clause (iv)) there is not an excess of hospital beds in the area of such hospital, such payment shall be made (during such period) on the basis of the amount otherwise payable under part A with respect to inpatient hospital services.

* * * * * * *

(2)(A) If the bed and board furnished as part of inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psychiatric hospital services) or [post-hospital] extended care services is in accommodations more expensive than semi-private accommodations, the amount taken into account for purposes of payment under this title with respect to such services may not exceed the amount that would be taken into account with respect to such services if furnished in such semi-private accommodations unless the more expensive accommodations were required for medical reasons

* * * * * * *

(3) If the bed and board furnished as part of inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psychiatric hospital services) or [post-hospital] extended care services is in accommodations other than, but not more expensive than, semi-private accommodations and the use of such other accommodations rather than semi-private accommodations was neither at the request of the patient nor for a reason which the Secretary determines is consistent with the purposes of this title, the amount of the payment with respect to such bed and board under part A shall be the amount otherwise payable under this title for such bed and board furnished in semi-private accommodations minus the difference between the charge customarily made by the hospital or skilled nursing facility for bed and board in semi-private accommodations and the charge customarily made by it for bed and board in the accommodations furnished.

* * * * * * *

[Post-Hospital] Extended Care in Christian Science Skilled Nursing Facilities

(y)(1) The term "skilled nursing facility" also includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, but only [(except for purposes of subsection (a)(2))] with respect to items and services ordinarily furnished by such an institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations.

(2) Notwithstanding any other provision of this title, payment under part A may not be made for services furnished an individual in a skilled nursing facility to which paragraph (1) applies unless such individual elects, in accordance with regulations, for a [spell of illness] to have such services treated as [post-hospital] extended care services for purposes of such part; and payment under part A may not be made for [post-hospital] extended care services—

(A) furnished an individual during such [spell of illness] *year* in a skilled nursing facility to which paragraph (1) applies after—

(i) such services have been furnished to him in such a facility for 30 days during such [spell] *year,* or

(ii) such services have been furnished to him during such [spell] *year* in a skilled nursing facility to which such paragraph does not apply; or

(B) furnished an individual during such [spell of illness] *year* in a skilled nursing facility to which paragraph (1) does not apply after such services have been furnished to him during such [spell] *year* in a skilled nursing facility to which such paragraph applies.

(3) The amount payable under part A for [post-hospital] extended care services furnished an individual during any [spell of illness] *year* in a skilled nursing facility to which paragraph (1) applies shall be reduced by a coinsurance amount [equal to one-eighth of the inpatient hospital deductible for each day before the 31st day] *equal to the coinsurance amount established under section 1813(a)(3)(C) for each day before the 8th day* on which he is furnished such services in such a facility during such [spell] *year* and the reduction under this paragraph shall be in lieu of any reduction under section 1813(a)(3)).

[(4) For purposes of subsection (i), the determination of whether services furnished by or in an institution described in paragraph (1) constitute post-hospital extended care services shall be made in accordance with and subject to such conditions, limitations, and requirements as may be provided in regulations.]

* * * * * * *

In-Home Care; Chronically Dependent Individual

(ff)(1) The term 'in-home care" means the following items and services furnished, under the supervision of a registered professional nurse, to a chronically dependent individual (as defined in paragraph (2)) by a home health agency or by others under arrangments with them made by such agency in a place of residence used as such individual's home:

(A) Services of a homemaker/home health aide (who has successfully completed a training program approved by the Secretary).

(B) Personal care services.

(C) Nursing care provided by a licensed professional nurse.

(2) The term "chronically dependent individual" means an individual who—

(A) is dependent on a daily basis on a primary caregiver who is living with the individual and is assisting the individual without monetary compensation in the performance of at least 2 of the activities of daily living (described in paragraph (3)), and

(B) without such assistance could not perform such activities of daily living.

(3) The "activities of daily living", referred to in paragraph (2), are as follows:

(i) Eating.

(ii) Bathing.

(iii) Dressing.

(iv) Toileting.

(v) Transfering in and out of a bed or in and out of a chair.

EXCLUSIONS FROM COVERAGE

SEC. 1862. (a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

(1)(A) which, except for items and services described in [subparagraph (B), (C), or (D)] *a succeeding subparagraph of this paragraph,* are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member,

(B) in the case of items and services described in section 1861(s)(10), which are not reasonable and necessary for the prevention of illness,

(C) in the case of hospice care, which are not reasonable and necessary for the palliation or management of terminal illness,

(D) in the case of clinical care items and services provided with the concurrence of the Secretary and with respect to research and experimentation conducted by, or under contract with, the Prospective Payment Assessment Commission or the Secretary, which are not reasonable and necessary to carry out the purposes of section 1886(e)(6), [and]

(E) in the case of research conducted pursuant to section 1875(c), which is not reasonable and necessary to carry out the purposes of that section; *and*

(F) in the case of in-home care for chronically dependent individuals, which is not reasonable and necessary to assure the health and condition of the individual is maintained in the individual's noninstitutional residence;

* * * * * * *

(6) which constitute personal comfort items (except, in the case of hospice care, as is otherwise permitted under paragraph (1)(C) *and except, in the case of in-home care, as is otherwise permitted under paragraph (1)(F);*

* * * * * * *

AGREEMENTS WITH PROVIDERS OF SERVICES

SEC. 1866. (a)(1) * * *

* * * * * * *

(2)(A) A provider of services may charge such individual or other person (i) the amount of any deduction or coinsurance amount imposed pursuant to section 1813(a)(1), (a)(3) or (a)(4), section 1833(b), or section 1861(v)(3) with respect to such items and services (not in excess of the amount customarily charged for such items and services by such provider) *the amount of any deduction imposed pursuant to section 1833(m)(1) with respect to covered outpatient drugs,* and (ii) an amount equal to so 20 per centum of the reasonable charges for such items and services (not in excess of 20 per centum of the amount customarily charged for such items and services by such provider) for which payment is made under part B (but in the case of items and services furnished to individuals with end-stage renal disease, an amount equal to 20 percent of the estimated amounts for such items and services calculated on the basis established by the Secretary). In the case of items and services described in section 1988(c)(1), clause (ii) of the preceding sentence shall be applied by substituting for 20 percent the proportion which is appropriate under such section. A provider of services may not impose a charge under clause (ii) of the first sentence of this subparagraph with respect to items and services described in section 1861(s)(10)(A), with respect to items and services furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion), and with respect to clinical diagnostic laboratory tests for which payment is made under part B or which are durable medical equipment furnished as home health services. *A provider of services may not impose a charge under the first sentence of this subparagraph for services for which payment is made to the provider pursuant to section 1833(f) (relating to catastrophic benefits.).*

* * * * * * *

(b) An agreement with the Secretary under this section may be terminated—

(1) * * *

* * * * * * *

(3) in the case of inpatient hospital services (including inpatient psychiatric hospital services) or [post-hospital] extended care services, with respect to services furnished after the effective date of such termination, except that payment may be made for up to thirty days with respect to inpatient institutional services furnished to any eligible individual who was admitted to such institution prior to the effective date of such termination,

* * * * * * *

(d) If the Secretary finds that there is a substantial failure to make timely review in accordance with section 1861(k) of long-stay cases in a hospital or skilled nursing facility, he may, in lieu of terminating his agreement with such hospital or facility, decide that, with respect to any individual admitted to such hospital or facility after a subsequent date specified by him, no payment shall be made under this title for inpatient hospital services (including inpatient psychiatric hospital services) after the 20th day of a continuous period of such services or for [post-hospital] extended care services after such day of a continuous period of such care as is prescribed in or pursuant to regulations, as the case may be. Such decision may be made effective only after such notice to the hospital, or (in the case of a skilled nursing facility) to the facility and the hospital or hospital with which it has a transfer agreement, and to the public, as may be prescribed by regulations, and its effectiveness shall terminate when the Secretary finds that the reason therefor has been removed and that there is reasonable assurance that it will not recur. The Secretary shall not make any such decision except after reasonable notice and opportunity for hearing to the institution or agency affected thereby.

* * * * * * *

PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS

SEC. 1876. (a)(1)(A) * * *

* * * * * * *

(c)(1) * * *

* * * * * * *

(8) In the case of an individual who enrolls as a member of an eligible organization under this section after January 1 of a year, the organization must take into account, in computing the expenses incurred for covered outpatient drugs for purposes of meeting the deductible under section 1833(m)(1)(A) for the year, expenses incurred for covered outpatient drugs during the year while the individual was entitled to benefits under part B but before the individual so enrolled.

* * * * * * *

VOLUNTARY CERTIFICATION OF MEDICARE SUPPLEMENTAL HEALTH INSURANCE POLICIES

SEC. 1882. (a) * * *

(b)(1) * * *

* * * * * * *

(3) Notwithstanding paragraph (1), in the case of a medicare supplemental policy offered in a State and in effect on January 1, 1988, the policy shall not be deemed to meet the standards and requirements set forth in subsection (c), unless each individual who is entitled to benefits under this title and is a policyholder under such policy on January 1, 1988, is sent a letter by not later than January 31, 1988, that explains—

(A) the improved benefits under this title contained in legislation enacted by the first session of the 100th Congress, and

(B) How these improvements affect the benefits contained in the policies and the premium for the policy.

(4) Notwithstanding paragraph (1), a medicare supplemental policy offered in a State shall not be deemed to meet the standards and requirements set forth in subsection (c), with respect to a advertisement (whether through written, radio, or television medium) used (or, at a State's option, to be used) for the policy in the State, unless the entity issuing the policy provides a copy of each advertisement to the Commissioner of Insurance (or comparable officer identified by the Secretary) of that State for his or her review in accordance with State law.

* * * * * * *

HOSPITAL PROVIDERS OF EXTENDED CARE SERVICES

SEC. 1883. (a) * * *

* * * * * * *

(d) Any agreement with a hospital under this section shall provide that payment for services will be made only for services for which payment would be made as [post-hospital] extended care services if those services had been furnished by a skilled nursing facility under an agreement entered into under section 1866; and any individual who is furnished services, for which payment may be made under an agreement under this section, shall, for purposes of this title (other than this section), be deemed to have received [post-hospital] extended care services in like manner and to the same extent as if the services furnished to him had been [post-hospital] extended care services furnished by a skilled nursing facility under an agreement under section 1866.

* * * * * * *

(f) A hospital which enters into an agreement with the Secretary under this section shall be required to meet those conditions applicable to skilled nursing facilities relating to discharge planning and the social services function (and staffing requirements to satisfy it) which are promulgated by the Secretary under section 1861(j)(15). Services furnished by such a hospital which would otherwise constitute [post-hospital] extended care services if furnished by a skilled nursing facility shall be subject to the same requirements applicable to such services when furnished by a skilled nursing facility except for those requirements the Secretary deter-

mines are inappropriate in the case of these services being furnished by a hospital under this section.

* * * * * * *

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

* * * * * * *

STATE PLANS FOR MEDICAL ASSISTANCE

SEC. 1902. (a) A State plan for medical assistance must—

(1) * * *

* * * * * * *

(10) provide—

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5) and (17) of section 1905(a), to—

(i) all individuals—

(I) who are receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A or part E of title IV (including individuals eligible under this title by reason of section 402(a)(37), 406(h), or 473(b), or considered by the State to be receiving such aid as authorized under section 414(g)).

(II) with respect to whom supplemental security income benefits are being paid under title XVI or who are qualified severely impaired individuals (as defined in section 1905(q)), or

(III) who are qualified pregnant women or children as defined in section 1905(n);

and, to the extent required under subsection (m)(3), some or all of the individuals described in subsection (l)(1);

* * * * * * *

(C) that if medical assistance is included for any group of individuals described in section 1905(a) who are not described in subparagraph (A) or (E), then—

(i) the plan must include a description of (I) the criteria for determining eligibility of individuals in the group for such medical assistance, (II) the amount, duration, and scope of medical assistance made available to individuals in the group, and (III) the single standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligibility, which shall be [the same] *no more restrictive than the* methodology which would be employed under the supplemental security income program in the case of groups consisting of aged, blind, or disabled individuals in a State in which such program is in effect, and which shall be [the same] *no more restrictive than the* methodology which would be employed under the

appropriate State plan (described in subparagraph (A)(i)) to which such group is most closely categorically related in the case of other groups;

* * * * * *

(E) [at the option of a State, but] subject to subsection (m)(3), for making medical assistance available for medicare cost-sharing (as defined in section 1905(p)(3)) for qualified medicare beneficiaries described in section 1905(p)(1);

* * * * * * *

(46) provide that information is requested and exchanged for purposes of income and eligibility verification in accordance with a State system which meets the requirements of section 1137 of this Act; [and]

(47) at the option of the State, provide for making ambulatory prenatal care available to pregnant women during a presumptive eligibility period in accordance with section 1920[.]; [(47)] *(48)* provide a method of making cards evidencing eligibility for medical assistance available to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address[.]; *and*

(49)(A) meet the requirements of section 1921 (relating to protection of community spouses), and (B) meet the requirement of section 1917(c) (relating to transfer of assets).

* * * * * * *

The requirement of clause (A) of paragraph (37) with respect to a State plan may be waived by the Secretary if he finds that the State has exercised good faith in trying to meet such requirement. For purposes of this title, any child who meets the requirements of paragraph (1) or (2) of section 473(b) shall be deemed to be a dependent child as defined in section 406 and shall be deemed to be a recipient of aid to families with dependent children under part A of title IV in the State where such child resides. Notwithstanding paragraph (10)(B) or any other provision of this subsection, a State plan shall provide medical assistance with respect to an alien who is not lawfully admitted for permanent residences or otherwise permanently residing in the United States under color of law only in accordance with section 1903(v). *For purposes of paragraph (10), methodology is considered to be "no more restrictive" if, using the methodology, additional individuals may be eligible for medical assistance and no individuals who are otherwise eligible are made ineligible for such assistance.*

* * * * * *

DEFINITIONS

SEC. 1905. For purposes of this title—

(a) * * *

* * * * * * *

(p)(1) The term "qualified medical beneficiary" means an individual—

(A) who is entitled to hospital insurance benefits under part A of title XVIII (including an individual entitled to such benefits pursuant to an enrollment under section 1818),

(B) who, but for section 1902(a)(10)(E) [and the election of the State], is not eligible for medical assistance under the plan,

(C) whose income (as determined under section 1612 for purposes of the supplemental security income program) does not exceed an income level established by the State consistent with paragraph [(2)(A)] *(2),* and

(D) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed [(except as provided in paragraph (2)(B))] *twice* the maximum amount of resources that an individual may have and obtain benefits under that program.

[(2)(A)] *(2)* The income level established under paragraph (1)(C) [may not exceed a percentage (not more than 100 percent) of the nonfarm] *shall be 100 percent of the* official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

[(B) In the case of a State that provides medical assistance to individuals not described in section 1902(a)(10)(A) and at the State's option, the State may use under paragraph (1)(D) such resource level (which is higher than the level described in that paragraph) as may be applicable with respect to individuals described in paragraph (1)(A) who are not described in section 1902(a)(10)(A).]

(3) The term "medicare cost-sharing" means the following costs incurred with respect to a qualified medicare beneficiary:

(A) Premiums [under part B and (if applicable) under section 1818] *under title XVIII (including under part B and, if applicable, under section 1818).*

[(B) Deductibles and coinsurance described in section 1813.

[(C) The annual deductible described in section 1833(b).]

(B) Coinsurance under title XVIII (including coinsurance described in section 1813).

(C) Deductibles established under title XVII (including those described in section 1813 and 1833(b) and, subject to paragraph (4), the annual deductible under section 1833(m)(1)).

(D) The difference between the amount that is paid under section 1833(a) and the amount that would be paid under such section if any reference to "80 percent" therein were deemed a reference to "100 percent".

Such term also may include, at the option of a State, premiums for enrollment of a qualified medicare beneficiary with an eligible organization under section 1876.

(4) Instead of providing to qualified medicare beneficiaries, under paragraph (3)(C), medicare cost-sharing with respect to the annual deductible for covered outpatient drugs under section 1833(m) (1), a State may provide to such beneficiaries, before charges for covered outpatient drugs for a year reach such deductible amount, benefits for prescribed drugs in the same amount, duration, and scope as the benefits made available under the State plan for individuals described in subsection (a) (10) (A) (i).

(5) Notwithstanding any other provision of this title, in the case of a State (other than the 50 States and the District of Columbia)—

(A) the requirement stated in section 1902(a) (10) (E) shall be optional, and

(B) for purposes of paragraph (2) (A), the State may substitute for 100 percent any lesser percentage.

* * * * * * *

LIENS, ADJUSTMENTS AND RECOVERIES, AND TRANSFERS OF ASSETS

Sec. 1917. (a) * * *

* * * * * * *

[(c)(1) Notwithstanding any other provision of this title, an individual who would otherwise be eligible for medical assistance under the State plan approved under this title may be denied such assistance if such individual would not be eligible for such medical assistance but for the fact that he disposed of resources for less than fair market value. If the State plan provides for the denial of such assistance by reason of such disposal of resources, the State plan shall specify a procedure for implementing such denial which, except as provided in paragraph (2), is not more restrictive than the procedure specified in section 1613(c) of this Act, and which may provide for a waiver of denial of such assistance in any instance where the State determines that such denial would work an undue hardship.

[(2)(A) In any case where the uncompensated value of disposed of resources exceeds $12,000, the State plan may provide for a period of ineligibility which exceeds 24 months. If a State plan provides for a period of ineligiblity exceeding 24 months, such plan shall provide for the period of ineligiblity to bear a reasonable relationship to such uncompensated value.

[(B)(i) In the case of any individual who is an inpatient in a skilled nursing facility, intermediate care facility, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs, and, who at any time during or after the 24-month period immediately prior to application for medical assistance under the State plan, disposed of a home for less than fair market value, the State plan (subject to clause (iii) may provide for a period of ineligibility for medical assistance in accordance with clause (ii).

[(ii) If the State plan provides for a period of ineligibility under clause (i), such plan—

[(I) shall provide that such individual shall be ineligible for all medical assistance for a period of 24 months after the date on which he disposed of such home, except that, in the case where the uncompensated value of the home is less than the average amount payable under the State plan as medical assistance for 24 months of care in a skilled nursing facility, the period of ineligiblity shall be such shorter time as bears a reasonable relationship (based upon the average amount payable

under the State plan as medical assistance for care in a skilled nursing facility) to the uncompensated value of the home, and

[(II) may provide (at the option of the State) that, in the case where the uncompensated value of the home is more than the average amount payable under the State plan as medical assistance for 24 months of care in a skilled nursing facility, such individual shall be ineligible for all medical assistance for a period in excess of 24 months after the date on which he disposed of such home which bears a reasonable relationship (based upon the average amount payable under the State plan as medical assistance for care in a skilled nursing facility) to the uncompensated value of the home.

[(iii) An individual shall not be ineligible for medical assistance by reason of clause (ii) if—

[(I) a satisfactory showing is made to the State (in accordance with any regulations promulgated by the Secretary) that the individual can reasonably be expected to be discharged from the medical institution and to return to that home,

[(II) title to such home was transferred to the individual's spouse or child who is under age 21, or (with respect to States eligible to participate in the State program established under title XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1614,

[(III) a satisfactory showing is made to the State (in accordance with any regulations promulgated by the Secretary) that the individual intended to dispose of the home either at fair market value, or for other valuable consideration, or

[(IV) the State determines that denial of eligibility would work an undue hardship.

[(3) In any case where an individual is ineligible for medical assistance under the State plan solely because of the applicability to such individual of the provisions of section 1613(c), the State plan may provide for the eligibility of such individual for medical assistance under the plan if such individual would be so eligible if the State plan requirements with respect to disposal of resources applicable under paragraphs (1) and (2) of this subsection were applied in lieu of the provisions of section 1613(c).]

(c)(1) In order to meet the requirements of this subsection (for purposes of section 1902(a)(49)(B)), the State plan must provide for a period of ineligibility in the case of an institutionalized individual (as defined in paragraph (3)) who, at any time during the 24-month period immediately before the individual's application for medical assistance under the State plan, disposed of resources for less than fair market value. The period of ineligibility shall begin with the month in which such resources were transferred and the number of months in such period shall be equal to (A) the total uncompensated value of the resources so transferred, divided by (B) the average cost, to a private patient at the time of the application, of nursing home care in the State or, at State option, in the community in which the individual is institutionalized.

(2) An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that—

(A) the resources transferred were a home and title to the home was transferred to the individual's spouse or child who is under age 21, or (with respect to State eligible to participate in the State program established under title XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1614;

(B) the resources were transferred to (or to another for the sole benefit of) the community spouse, as defined in section 1921(g)(2);

(C) a satisfatory showing is made to the State (in accordance with any regulations promulgated by the Secretary) that the individual intended to dispose of the resources either at fair market value, or for other valuable consideration; and

(D) the State determines that denial of eligibility would work an undue hardship.

(3) In this subsection, the term "institutionalized individual" means an individual who—

(A) is an inpatient in a skilled nursing facility, intermediate care facility, or other medical institution and

(B) is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

(4) A State may not provide for any period of ineligibility for an institutionalized individual due to transfer of resources for less than fair market value except in accordance with this subsection.

TREATMENT OF INCOME AND RESOURCES FOR CERTAIN INSTITUTIONALIZED SPOUSES

SEC. 1921. (a) SPECIAL TREATMENT FOR INSTITUTIONALIZED SPOUSES.—

(1) SUPERSEDES OTHER PROVISIONS.—In determining the eligibility for medical assistance of an institutionalized spouse (as defined in subsection (g)(1)), the provisions of this section supersede any other provision of this title (including sections 1902(a)(17) and 1902(f)) which is inconsistent with them.

(2) NO COMPARABLE TREATMENT REQUIRED.—Any different treatment provided under this section for institutionalized spouses shall not, by reason of paragraph (10) or (17) of section 1902(a), require such treatment for other individuals.

(3) DOES NOT AFFECT CERTAIN DETERMINATIONS.—Except as this section specifically provides, this section does not apply to—

(A) the determination of what constitutes income or resources, or

(B) the methodology and standards for determining and evaluating income and resources.

(4) ELECTION TO USE OTHER RULES.—An institutionalized spouse may elect not to have this section (other than subsection (c)) apply but to have the spouse's resources and income determined under the law, practice, or policy of the plan (whether

approved or not) in effect on March 1, 1987, except to the extent inconsistent with subsection (c).

(5) APPLICATION IN CERTAIN STATES AND TERRITORIES.—

(A) APPLICATION IN STATES OPERATING UNDER DEMONSTRATION PROJECTS.—In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115, the Secretary shall require the State to meet the requirements of this section in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this title XIX.

(B) NO APPLICATION IN COMMONWEALTHS AND TERRITORIES.—This section shall only apply to a State that is one of the 50 States or the District of Columbia.

(b) RULES FOR TREATMENT OF INCOME.—

(1) SEPARATE TREATMENT OF INCOME.—During any month in which an institutionalized spouse is in the institution, no income of the community spouse shall be deemed available to the institutionalized spouse.

(2) ATTRIBUTION OF INCOME.—In determining the income of an institutionalized spouse or community spouse, except as otherwise provided in this section and regardless of any State laws relating to community property or the division of marital property, the following rules apply:

(A) NON-TRUST PROPERTY.—Subject to subparagraphs (C) and (D), in the case of income not from a trust, unless the instrument providing the income otherwise specifically provides—

(i) if payment of income is made solely in the name of the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;

(ii) if payment of income is made in the names of the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them; and

(iii) if payment of income is made in the names of the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each of the individuals named in equal proportional shares.

(B) TRUST PROPERTY.—In the case of a trust—

(i) except as provided in clause (ii), income shall be attributed in accordance with the provisions of this title (including sections 1902(a)(17) and 1902(k)), and

(ii) unless the trust otherwise specifically provides—

(I) if payment of income is made solely to the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;

(II) if payment of income is made to both the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them; and

(III) if payment of income is made to the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each of such individuals in equal proportional shares.

(C) PROPERTY WITH NO INSTRUMENT.—In the case of income not from a trust in which there is no instrument establishing ownership, subject to subparagraph (D), one-half of the income shall be considered to be available to the institutionalized spouse and one-half to the community spouse.

(D) REBUTTING OWNERSHIP.—The rules of subparagraphs (A) and (C) are superceded to the extent that an institutionalized spouse can establish, by a preponderance of the evidence, that the ownership interests in income are other than as provided under such subparagraphs.

(c) RULES FOR TREATMENT OF RESOURCES.

(1) COMPUTATION OF SPOUSAL SHARE AT TIME OF INSTITUTIONALIZATION.—There shall be computed (as of the beginning of a continuous period of institutionalization of the institutionalized spouse) a spousal share which is equal to ½ of the value of all the resources held by either the institutionalized spouse, community spouse, or both.

(2) ATTRIBUTION OF RESOURCES AT TIME OF INITIAL ELIGIBILITY DETERMINATION.—In determining the resources of an institutionalized spouse at the time of application for benefits under this title, regardless of any State laws relating to community property or the division of marital property—

(A) except as provided in subparagraph (B), all the resources held by either the institutionalized spouse, community spouse, or both, shall be considered to be available to the institutionalized spouse, and

(B) resources held in the name of (or for the sole benefit of) the community spouse shall not be considered to be available to an institutionalized spouse, to the extent that the amount of such resources does not exceed the amount computed under subsection (e)(2)(A) (as of the time of application for benefits), or, if greater, the amount that a court has ordered to be retained by the community spouse for the support of the community spouse.

(3) SEPARATE TREATMENT OF RESOURCES AFTER ELIGIBILITY FOR BENEFITS ESTABLISHED.—During the continuous period in which an institutionalized spouse is in an institution and after the month in which an institutionalized spouse is determined to be eligible for benefits under this title, no resources of the community spouse shall be deemed available to the institutionalized spouse.

(4) RESOURCES DEFINED.—In this section, the term "resources" does not include resources excluded under subsection (a) or (d) of section 1613 and does not include resources that would be excluded under section 1613(a)(2)(A) but for the limitation on total value described in such section.

(c) PROTECTING INCOME FOR COMMUNITY SPOUSE.—

(1) ALLOWANCES TO BE OFFSET FROM INCOME OF INSTITUTIONALIZED SPOUSE.—After an institutionalized spouse is determined to be eligible for medical assistance, in determining the amount of the spouse's income that is to be applied monthly to payment for the costs of care in the institution, there shall be deducted from the spouse's monthly income the following amounts in the following order:

(A) A personal needs allowance that is reasonable in amount for clothing and other personal needs of the institutionalized spouse and which is not less than $25 per month.

(B) A community spouse monthly income allowance (as defined in paragraph (2)), but only to the extent income of the institutionalized spouse is made available to (or for the benefit of) the community spouse.

(C) A family allowance, for each family member, equal to at least one-third of the amount by which the amount described in paragraph (3)(A)(i) exceeds the amount of the montly income of that family member.

(D) Amounts for incurred expenses for medical or remedial care for the institutionalized spouse that are not subject to payment by a legally liable third party.

In subparagraph (C), the term "family member" only includes minor or dependent children, dependent parents, or dependent siblings of the institutionalized or community spouse who are residing with the community spouse.

(2) COMMUNITY SPOUSE MONTHLY INCOME ALLOWANCE DEFINED.—In this section (except as provided in paragraph (6)), the "community spouse montly income allowance" for a community spouse is an amount by which—

(A) except as provided in paragraph (4), the minimum monthly maintenace needs allowance (established under and in accordance with paragraph (3)) for the spouse, exceeds

(B) the amount of montly income otherwise available to the community spouse (determined without regard to such an allowance).

(3) ESTABLISHMENT OF MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—

(A) IN GENERAL.—Each State shall establish a minimum monthly maintenance needs allowance for each community spouse which, subject to subparagraph (B), is equal to or exceeds—

(i) 150 percent of one-twelfth of the nonfarm income official poverty line (defined by the Office of Management and Budget and revised annually in accordance with sections 652 and 673(2) of the Omnibus Budget Reconciliation Act of 1981) for a family unit of 2 members; plus

(ii) an excess shelter allowance (as defined in paragraph (5)); plus

(iii) one-half of the amount by which the income available to the institutionalized spouse exceeds the sume of the amounts described in clauses (i) and (ii).

A revision of the official poverty line referred to in clause (i) shall apply to medical assistance furnished during and after the second calendar quarter that begins after the date of publication of the revision.

(B) CAP ON MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—The minimum monthly maintenance needs allowance established under subparagraph (A) may not exceed $1,500 (subject to adjustment under subsection (f)).

(4) NOTICE AND FAIR HEARING.—

(A) NOTICE.—Upon—

(i) a determination of eligiblity for medical assistance of an institutionalized spouse, or

(ii) a request by an institutionalized spouse (or community spouse or representative on the spouse's behalf),

each State shall notify the spouse of the amount of the community spouse monthly income allowance (described in paragraph (1)(B)), of the amount of any family allowances (described in paragraph (1)(c)), of the method for computing the amount of the community spouse resources allowance permitted under subsection (e), and of the spouse's right to a fair hearing under subparagraph (B) respecting the determination of the community spouse monthly income allowance.

(B) FAIR HEARING.—If an institutionalized spouse is dissatisfied with a determination of—

(i) the community spouse monthly income allowance because the amount of the minimum monthly maintenance needs allowance (established under paragraph (3)) is not adequate to support the community spouse without financial duress, or

(ii) the amount of monthly income otherwise available to the community spouse (as applied under paragraph (2)(B)),

the institutionalized spouse is entitled to a fair hearing described in section 1902(a)(3) with respect to such determination. If the institutionalized spouse establishes that the minimum monthly maintenance needs allowance is not adequate to support the community spouse without financial duress, there shall be substituted, for the minimum monthly maintenance needs allowance in paragraph (2)(A), an amount adequate to support the community spouse without financial duress.

(5) EXCESS SHELTER ALLOWANCE DEFINED.—In paragraph (3)(A)(ii), the term "excess shelter allowance" means, for a community spouse, the amount by which the sum of—

(A) the spouse's expenses for mortgage payment (including principal, interest, taxes, and insurance and, in the case of a condominium or cooperative, required maintenance charge) or rent, and

(B) the standard utility allowance (used by the State under section 5(e) of the Food Stamp Act of 1977) or, if the State does not use such an allowance, the spouse's actual utility expenses,

exceeds 30 percent of the amount described in paragraph (3)(A)(i), except that, in the case of a condominium or cooperative, for which a maintenance charge is included under subparagraph (A), any allowance under subparagraph (B) shall be reduced to the extent the maintenance charge includes utility expenses.

(6) COURT ORDERED SUPPORT.—If a court has entered an order against an institutionalized spouse for monthly income for the support of the community spouse, the community spouse monthly income allowance for the spouse shall be not less than the amount of the monthly income so ordered.

(e) PERMITTING TRANSFER OF RESOURCES TO COMMUNITY SPOUSE.—

(1) IN GENERAL.—An institutionalized spouse may, without regard to section 1917, transfer to the community spouse (or to another for the sole benefit of the community spouse) an amount equal to the community spouse resource allowance (as defined in paragraph (2)), but only to the extent the resources of the institutionalized spouse are transferred to (or for the sole benefit of) the community spouse.

(2) COMMUNITY SPOUSE RESOURCE ALLOWANCE DEFINED.—In paragraph (1), the "community spouse resource allowance" for a community spouse is an amount (if any) by which—

(A) the greater of—

(i) $12,000 (subject to adjustment under subsection (f)), or

(ii) the lesser of (I) the spousal share computed under subsection (c)(1), or (II) 4 times the amount described in clause (i), exceeds

(B) the amount of the resources otherwise available to the community spouse (determined without regard to such an allowance).

(3) TRANSFERS UNDER COURT ORDERS.—If a court has enterned an order against an institutionalized spouse for the support of the community spouse, section 1917 shall not apply to amounts of resources transferred pursuant to such order for the support of the spouse of a family member (as defined in subsection (d)(1)).

(f) INDEXING DOLLAR AMOUNTS.—For services furnished during a calendar year after 1988, the dollar amounts specified in subsections (d)(3)(B) and (e)(2)(A)(i) shall be increased by the same percentage as the percentage increase in the consumer price index for all urban consumers (all items; U.S. city average) between September 1987 and the September before the calendar year involved.

(g) DEFINITIONS.—In this section:

(1) The term "institutionalized spouse" means an individual who—

(A) is in a hospital, skilled nursing facility, or intermediate care facility, or who (at the option of the State) is described in section 1902(a)(10)(A)(ii)(VI), and

(B) is married to a spouse who is not in a hospital, skilled nursing facility, or intermediate care facility; but does not include any such individual who is not likely to

meet the requirements of subparagraph (A) for at least 30 consecutive days.

(2) The term "community spouse" means the spouse of an institutionalized spouse.

REFERENCES TO LAWS DIRECTLY AFFECTING MEDICAID PROGRAM

SEC. [1921] *1922.* (a) AUTHORITY OR REQUIREMENTS TO COVER ADDITIONAL INDIVIDUALS.—For provisions of law which make additional individuals eligible for medical assistance under this title, see the following:

(1) AFDC.—(A) Section 402(a)(32) of this Act (relating to individuals who are deemed recipients of aid but for whom a payment is not made). Section 402(a)(37) of this Act (relating to individuals who lose AFDC eligibility due to increased earnings).

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INTERNAL REVENUE CODE OF 1986

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Subtitle A—Income Taxes

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CHAPTER 1—NORMAL TAXES AND SURTAXES

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Subchapter A—Determination of Tax Liability

Part I. Tax on individuals.

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Part VIII. Supplemental medicare premium.

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PART VIII—SUPPLEMENTAL MEDICARE PREMIUM

See. 59B. Imposition of supplemental medicare premium.

SEC. 59B. IMPOSITION OF SUPPLEMENTAL MEDICARE PREMIUM.

(a) IMPOSITION OF PREMIUM.—In the case of a medicare-eligible individual, there is hereby imposed (in addition to any other amount imposed by this subtitle) for each taxable year a premium equal to the annual premium for such year determined under subsection (b).

(b) DETERMINATION OF AMOUNT.—For purposes of this section—

(1) IN GENERAL.—Except as otherwise provided in this subsection—

If the adjusted gross income for the taxable year is:

Over:	But not over:	The annual premium for the taxable year is:
$0	$6,000	$0
6000	6,143	10
6,143	6,287	20
6,287	6,430	30
6,430	6,573	40
6,573	6,716	50
6,716	6,860	60
6,860	7,003	70
7,003	7,146	80
7,146	7,289	90
7,289	7,433	100
7,433	7,576	110
7,576	7,719	120
7,719	7,862	130
7,862	8,006	140
8,006	8,149	150
8,149	8,292	160
8,292	8,436	170
8,436	8,579	180
8,579	8,722	190
8,722	8,865	200
8,865	9,009	210
9,009	9,152	220
9,152	9,295	230
9,295	9,438	240
9,438	9,582	250
9,582	9,725	260
9,725	9,868	270
9,868	10,011	280
10,011	10,155	290
10,155	10,298	300
10,298	10,441	310
10,441	10,585	320
10,585	10,728	330
10,728	10,871	340
10,871	11,014	350
11,014	11,158	360
11,158	11,301	370
11,301	11,444	380
11,444	11,587	390
11,587	11,731	400
11,731	11,874	410
11,874	12,017	420
12,017	12,160	430
12,160	12,304	440
12,304	12,447	450
12,447	12,590	460
12,590	12,734	470
12,734	12,877	480
12,877	13,020	490
13,020	13,163	500
13,163	13,307	510
13,307	13,450	520
13,450	13,593	530
13,593	13,736	540
13,736	13,880	550
13,880	14,023	560
14,023	14,166	570
14,166		580.

(2) Special rule where individual not eligible for entire taxable year; short taxable years.—If an individual is not a medicare-eligible individual for each month during his taxable year, the annual premium determined under this subsection shall be an amount which bears the same ratio to the amount determined under paragraph (1) as—

(A) the number of months during the taxable year for which such individual is a medicare-eligible individual, bears to

(B) 12.

A similar rule shall apply in the case of a taxable year of less than 12 months; except that adjusted gross income for the taxable year shall be annualized.

(3) Special rule for joint returns.—In the case of a joint return—

(A) this section shall be applied separately with respect to each spouse, and

(B) the adjusted gross income of each spouse shall be ½ of their combined adjusted gross income.

(4) Adjustments to table.—

(A) In general.—Not later than December 15 of 1988 and each subsequent calendar year, the Secretary shall prescribe a table which shall apply in lieu of the table contained in paragraph (1) with respect to taxable years beginning in the succeeding calendar year.

(B) Method of prescribing table.—The table which, under subparagraph (A), is to apply in lieu of the table contained in paragraph (1) with respect to taxable years beginning in any calendar year shall be prescribed—

(i) by increasing each dollar amount setting forth the amount of the premium in such table by the medicare inflation factor for such calendar year, and

(ii) by increasing each other dollar amount in such table by the cost-of-living adjustment for such calendar year (as defined in section 1(f)(3)).

(C) Medicare inflation factor.—For purposes of subparagraph (B), the medicare inflation factor for any calendar year is the percentage (if any) by which—

(i) the medicare value for such calendar year, exceeds

(ii) the medicare value for 1988.

(D) Rounding.—If any increase determined under subparagraph (B) is not a multiple of $1, such increase shall be rounded to the nearest multiple of $1.

(c) Definitions and Special Rules.—

(1) Medicare-eligible individual.—For purposes of this section—

(A) In general.—Except as otherwise provided in this paragraph, the term "medicare-eligible individual" means, with respect to any month, any individual who is entitled to (or, on application without the payment of an additional premium, would be entitled to) benefits under part A of title XVIII of the Social Security Act for such month.

(B) Exceptions.—The term "medicare-eligible individual" shall not include for any month—

(i) any individual who is entitled to benefits under part A of title XVIII of the Social Security Act for such month solely by reason of the payment of a premium under section 1818 of such Act,

(ii) any individual who is required to pay a premium for such month increased or computed under paragraph (4) or (5) of section 1839(e) of the Social Security Act, or

(iii) any qualified nonresident.

(C) TREATMENT OF INDIVIDUALS WHO HAVE ATTAINED AGE 65.—An individual (other than nonresident alien) who has attained age 65 shall be treated as a medicare-eligible individual for the month in which he attains age 65 and any subsequent month unless such individual establishes to the satisfaction of the Secretary that he is not a medicare-eligible individual for the month concerned.

(2) MEDICARE VALUE.—

(A) IN GENERAL.—For purposes of this section, the term "medicare value" means, for any calendar year, the sum of the Medicare Part A value for January of such calendar year and the Medicare part B valve for January of such calendar year.

(B) MEDICARE PART A VALUE.—For purposes of subparagraph (A), the term "Medicare part A value" means, with respect to any month, an amount equal to 50 percent of the monthly acturial rate promulgated under section 1818(d)(1) of the Social Security Act for such month.

(C) MEDICARE PART B VALUE.—For purposes of subparagraph (A), the term "Medicare part B value" means, with respect to any month, an amount equal to the excess of—

(i) the amount equal to twice the monthly actuarial rate established under section 1839(a)(1) of the Social Security Act for the calendar year which includes such month, over

(ii) the amount of the monthly premium for such month established under section 1839 of such Act (without regard to subsections (b), (e)(4), (e)(5), and (f) thereof).

(3) QUALIFIED NONRESIDENT.—

(A) IN GENERAL.—For purposes of paragraph (1), the term "qualified nonresident" means, with respect to any month during the taxable year, any individual if—

(i) such individual is not furnished during such taxable year or any of the 4 preceding taxable years any service for which a claim for payment is or will be made under part A of title XVIII of the Social Security Act,

(ii) such individual is not entitled to benefits under part B of title XVIII of the Social Security Act at any time during such taxable year or any of the 4 preceding taxable years, and

(iii) suh individual is present in a foreign country or countries for at least 330 full days during—

(I) the 12-month period ending at the close of the taxable year, and

(II) each of the 4 consecutive preceding 12-month periods.

(B) SPECIAL RULE FOR INDIVIDUALS WHO DIE DURING THE TAXABLE YEAR.—An individual who dies during the taxable year shall be treated as meeting the requirement of subparagraph (A)(iii)(I) if such individual is present in a foreign country or countries for at least a number of full days equal to 90 percent of the days during such taxable year before the date of death.

(4) COORDINATION WITH OTHER PROVISIONS.—

(A) NOT TREATED AS MEDICAL EXPENSE.—The premium imposed by this section shall not be treated as an expense paid for medical care for purposes of section 213.

(B) NOT TREATED AS TAX FOR CERTAIN PURPOSES.—The premium imposed by this section shall not be treated as a tax imposed by this chapter for purposes of determining—

(i) the amount of any credit allowable under this chapter, or

(ii) the amount of the minimum tax imposed by section 55.

(C) TREATED AS TAX FOR SUBTITLE F.—For purposes of subtitle F, the premium imposed by this section shall be treated as if it were a tax imposed by section 1.

(D) SECTION 15 NOT TO APPLY.—Section 15 shall not apply to the premium imposed by this section.

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Subtitle F—Procedure and Administration

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CHAPTER 61—INFORMATION AND RETURNS

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Subchapter A—Returns and Records

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PART III—INFORMATION RETURNS

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Subchapter B—Information Concerning Transactions With Other Persons

Sec. 6041. Information at source.

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Sec. 6050O. Returns relating to individuals entitled to receive benefits under Medicare part A.

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SEC. 6050O. RETURNS RELATING TO INDIVIDUALS ENTITLED TO RECEIVE BENEFITS UNDER MEDICARE PART A.

The Secretary of Health and Human Services shall make a return (at such times and in such form as the Secretary may prescribe) setting forth the name, address, and TIN of each individual who is entitled to receive benefits (other than by reason of the payment of a premium referred to in clause (i) or (ii) of section 59B(c)(1)(B)) under part A of title XVIII of the Social Security Act for any month during the calendar year and the number of months in the calendar year for which the individual is so entitled.

* * * * * * *

SECTION 9403 OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1986

SEC. 9403. OPTIONAL COVERAGE OF POOR MEDICARE BENEFICIARIES FOR MEDICARE COST-SHARING EXPENSES.

(a) * * *

* * * * * * *

(g) CONFORMING AMENDMENTS.—

(1) TREATMENT OF BENEFITS.—Section 1902(a)(10)(C) of such Act (42 U.S.C. 1396a(a)(10((C)) is amended, in the matter before clause (i), by inserting "or (E)" after "subparagraph (A)".

[(2) PAYMENT OF MEDICARE PREMIUMS AND PART A DEDUCTIBLE.—Section 1903(a)(1) of such Act (42 U.S.C. 1396b(a)(1)) is amended—

[(A) by inserting "deductible amounts under part A and" after "(including expenditures for",

[(B) by inserting "(and, in the case of qualified medicare beneficiaries described in section 1905(p)(1), part A)" after "premiums under part B", and

[(C) by striking "or (B)" and inserting "(B) are qualified medicare beneficiaries described in section 1905(p)(1), or (C)".]

(2) PAYMENT OF MEDICARE COST-SHARING.—Section 1903(a)(1) of such Act (42 U.S.C. 1396b(a)(1)) is amended by inserting "including expenditures for medicare cost-sharing and" before "including expenditures.".

* * * * * * *

SECTION 2355 OF THE DEFICIT REDUCTION ACT OF 1984

WAIVERS FOR SOCIAL HEALTH MAINTENANCE ORGANIZATIONS

SEC. 2355. (a) * * *

(b) A project referred to in subsection (a) is a project—

(1) * * *

* * * * * * *

(5) under which all payors will share risk for no more than two years, with the organization being at full risk in the third year *and in succeeding years;*

* * * * * * *

(d)(1) The Secretary of Health and Human Services shall submit a preliminary report to the Congress on the status of the projects and waivers referred to in subsection (a) 45 days after the date of the enactment of this Act.

(2) The Secretary shall submit a [final] *interim* report to the Congress on the projects referred to in subsection (a) not later than 42 months after the date of the enactment of this Act.

Dissenting Views on H.R. 2470—Medicare Catastrophic Protection Act

No one will argue that it is not a worthwhile task to devise a financing mechanism to reduce the risks involved with serious illness. For that reason, President Reagan received bipartisan support when he submitted legislation to Congress providing full acute care coverage to Medicare beneficiaries. Unfortunately, what began as an actuarially sound, simple reform to the Federal insurance program for the elderly has resulted in a broad expansion of Medicare benefits (largely for non-catastrophic care) financed through substantial increases in the program's existing premiums and by adding a new mandatory premium (which is essentially a tax) for nearly half of the program's beneficiaries.

The legislation considered by the Committee on Energy and Commerce, H.R. 2470 (as reported by the Committee on Ways and Means), may be titled the Medicare Catastrophic Protection Act of 1987, but its five-year program cost of $24 billion and estimated revenues from new taxes of over $26 billion should be considered the real catastrophe. Regretfully, this Committee's amending process further increased program outlays by an additional $13 billion over five years according to the Congressional Budget Office. These additional costs will result in nearly half of elderly beneficiaries experiencing a five-fold increase in their annual Medicare premiums.

To support this legislation is to do a great disservice to the elderly of this country. The value of the new benefits established in H.R. 2470 may not be proportionate to the substantial increase in premiums which millions of individuals over 65 will be mandated to pay. We opposed reporting H.R. 2470 when it was considered by the Committee because of the substantial increase in beneficiary premiums and program outlays. We strongly believe that a major expansion of the Medicare program will jeopardize its long-term solvency.

Because Title I of H.R. 2470 is not under the jurisdiction of the Committee on Energy and Commerce, we could make no changes to the provision in Title I which requires all tax-paying individuals eligible for Medicare to pay a supplemental premium. Though called a premium, it is mandatory, not deductible as a health care expense and collected by the Internal Revenue Service. The maximum surtax, as the premium is better known, is $580 in the first year alone and the Department of Treasury estimates it will increase to $830 in 1991. An elderly couple with an adjusted gross income of $34,000 would face a $1,160 increase to their current tax liability of approximately $2,700. We cannot support such a steep increase in premium payments when they have no direct relationship to the use or value of the increase in benefits established by the bill.

Additionally, this legislation greatly expands Medicare benefits for non-acute care catastrophic benefits, which may be worthwhile, but not appropriate for inclusion in Medicare catastrophic legislation. H.R. 2470 expands the current limit on outpatient mental health services, provides a new benefit for in-home care by a home health aide or homemaker, and allows that the expenses for certain routine cancer screening be included in the catastrophic out-of-pocket Part B limit. These expansions increase both program outlays (Federal spending) and beneficiary cost sharing for benefits that many Medicare eligibles do not consider essential. Regardless of how many of the elderly will utilize these benefits, all will pay for them. Due to the limits in the outyears on premium levels mandated in the legislation, the Federal Government will have to pick up an ever greater proportion of the total bill. If the rate at which costs increase is greater than the rate at which premiums are allowed to increase, the difference will have to come out of general revenues. We believe the elderly rely on Congres to maintain the long-term viability of the Medicare program. Clearly, we cannot justify the many non-acute care benefit expansions included in H.R. 2470 during a time of already astronomical Federal deficits.

Of particular concern to us is the Committee's addition of a catastrophic drug benefit to the Medicare program. The data from the Department of Health and Human Sevices, several States with drug programs, and private insurance companies show a wide variance in utilization and program costs. Many Medicare beneficiaries already pay for private Medigap policies that provide drug coverage and do not want to be saddled with an additional premium that pays for drugs only after a $500 deductible is met. We supported an amendment which would have required States to expand their Medicaid drug programs to include individuals over 65 who are at 200 percent of the Federal poverty level. For this population, the expense of out-patient drug therapy is truly catastrophic and should be provided through Federal and State financing.

In conclusion, we reaffirm our continued support and commitment to Medicare coverage for catastrophic acute care expenses and commend the President for his legislation. By establishing new program benefits in H.R. 2470, Congress has made a promise to the elderly. These programs, together with their funding mechanisms, will not be affordable to beneficiaries in the very near future—making this only a false promise. Therefore, we cannot be party to the legislation reported by this Committee, and we must voice our strong opposition.

Norman F. Lent.
Ed Madigan.
Carlos J. Moorhead.
Bill Dannemeyer.
Tom Tauke.
Dan Coats.
Thomas J. Bliley, Jr.
Jack Fields.
Michael G. Oxley.
Howard C. Nielson.
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